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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Health Resurvey 1QH611.<br><br>A revised copy of the deficiencies was e-mailed to the provider on 9-17-13.<br><br>A second revised copy of the deficiencies was e-mailed to the provider on 9-18-13. | F 000 | | |
| F 157 SS=E | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. | F 157 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 33 residents with 18 residents in the sample. Based on interview and record review the facility failed to notify the physician and/or responsible party of a significant change in condition for 3 sampled residents (#5, #30 and #11) related to severe weight loss and/or development of Stage 2 pressure ulcers.

Findings included:

- Review of resident # 5's medical record revealed the facility failed to notify the physician of significant weight loss in a timely manner.

Review of the resident medical record revealed the resident had a weight loss on 1/13 of 9.19% loss in 3 months from 11/12 to 1/13, weight loss on 2/13 of 6 pounds in 1 month from 1/13 to 2/13, and on 8/29/13, 5 pounds in 1 month.

The resident had a significant weight loss 3/13 of 24 pounds in 6 months 16.4% from 9/12 to 3/13.

Review of the residents weight record revealed that the resident was 176 pounds in 9/12. and by March 2013 the resident's weight had dropped to 147 pounds. No mention in the nurses notes of the physician notification until May 12,2013.

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Review of the facility policy for Physician Notification, last revised 6/13, revealed, "Conditions warranting notification of physician during normal business hours within 24 hours of occurrence or next business day* These lists are not all-inclusive, any time the nurse feels the situation warrants physician notification above and beyond these lists, do so... The nurse must then document the assessment and the conversation with the physician or clinic personnel in the chart.

The facility failed to ensure that the staff notified the physician of significant weight losses in a timely manner.

- Review of resident #30's closed medical record revealed the facility failed to notify the resident's physician of the development of 2 stage 2 pressure ulcers.

Review of the Weekly Skin Assessment sheet dated 6/2/13 revealed a 0.75 cm length x 0.75 cm width stage 2 pressure ulcer (open wound formed from prolonged pressure) to the right side of the resident's coccyx.

Review of the Interdisciplinary notes dated 6/3/13 at 2:00 p.m. revealed a 0.5 cm (centimeter) open area on the right and left buttock cheeks. The area was cleansed and covered with Allevyn thin. The progress note also revealed the resident had a 2 cm open area to the genital area. The note failed to identify notification of the wounds to the physician.

The facility failed to notify the resident's physician of the development of two stage avoidable pressure ulcers in a timely manner.

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- Review of resident #11's physician's orders sheet signed and dated on 7/24/13 revealed the facility failed to notify the physician of the resident continued significant weight loss.

Review of the resident's weight record revealed:

February 2013 - 186 pounds
March 2013 - 186 pounds
April 2013 - 174 pounds (a severe weight loss of 6.4 % in 1 month)
May 2013 - 175 pounds
June 2013 - 176 pounds
July 2013 - 166 pounds (5.6 % weight loss in 1 month)
August - 157 pounds ( a severe weight loss of 15.59 % in 6 months)

Review of the resident Nurses notes, Interdisciplinary, and Progress notes revealed the facility failed to notify the physician the resident continued to have significant weight loss with the prescribed interventions.

The facility failed to ensure that the staff notified the physician of significant weight losses in a timely manner.

- Review of resident #30's closed medical record revealed the facility failed to notify the resident's physician of the severe weight loss of 8.08% in 30 days.

Review of the resident's weight history revealed the following:

4/4/13 - 240 pounds

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4/22/13 - 240 pounds
5/1/13 - 221 pounds
5/17/13 - 222.5 pounds
5/25/13 - 220.6 pounds 8.08% weight loss in 30 days (from 4/22/13 to 5/25/13)

Review of the resident's Nurses notes, Interdisciplinary, and Progress notes revealed the facility failed to notify the resident's physician of the resident severe weight loss.

The facility failed to ensure that the staff notified the physician of significant weight losses in a timely manner.
- Review of resident #28's Weekly Skin Sheet dated 7/31/13 revealed the resident developed a stage II pressure ulcer (a shallow open ulcer with partial thickness loss of the dermis layer of the skin) between the buttocks on the right side that measured 6 cm (centimeters) x 2 cm without drainage and the form identified it had been developed in house.

Review of the resident's chart revealed no evidence staff notified the physician of the resident's pressure ulcer.

During an interview with licensed nursing staff H on 9/6/13 at 9:42 a.m., he/she looked in the resident's chart and confirmed there was no physician notification documented in any place he/she would have expected to find it.

Interview with administrative nursing staff A on 9/6/13 at 10:38 a.m. revealed when a pressure ulcer developed, he/she expected the staff to follow the policy and procedures for pressure ulcers, including notifying the physician.

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| F 157 | Continued From page 5<br>Review of the facility policy for Physician Notification, last revised 6/13, revealed, "Conditions warranting notification of physician during normal business hours within 24 hours of occurrence or next business day* ... New or worsening pressure ulcers ... These lists are not all-inclusive, any time the nurse feels the situation warrants physician notification above and beyond these lists, do so... The nurse must then document the assessment and the conversation with the physician or clinic personnel in the chart. Be sure to specify exactly which body part is being referred to in documentation."<br><br>The facility failed to notify the physician when the resident developed a stage II pressure ulcer. | F 157 | | |
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280 | | |

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This REQUIREMENT is not met as evidenced by:
The facility census totaled 33 residents with 18 included in the sample. All of the sampled residents' care plans were reviewed. Based on observation, interview, and record review, the facility failed to update care plans for 5 of the 18 sampled residents. (#28, 30, 11, 5, 17)

Findings included:

- Review of resident 28's signed physician orders dated 8/23/13 revealed a diagnosis of malnutrition (poor nutrition).

Review of the resident's admission MDS (minimum data set) dated 7/3/13 revealed a BIMS (brief interview for mental status) score of 6, indicating severe cognitive impairment. The resident required extensive assistance of one staff for bed mobility, eating, and personal hygiene, and extensive assistance of two staff for transfers and toileting. The MDS revealed the facility used a formal assessment tool to determine the resident's pressure ulcer risk and the resident was at risk of developing a pressure ulcer, but did not have any. The interventions the facility had in place to prevent pressure ulcers included a pressure relieving device for the chair and the bed, nutrition or hydration interventions, and applications of medications/ointments.

Review of the ADL (activities of daily living) Functional/Rehabilitation Potential CAA (care area assessment) dated 7/3/13 revealed the following analysis of findings: "[Gender] was

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recently in acute care for bilateral pneumonia [inflammation of the lungs], exacerbation of COPD [a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing], dehydration and malnutrition, anemia [a condition without enough healthy red blood cells to carry adequate oxygen to body tissues], and generalized deconditioning [a decrease in functioning of the heart muscle after a prolonged time of inactivity]... nutritional status is extremely poor and [gender] is weak... PT [physical therapy] is working with [gender] now 3 x [times] week and has shown a severe deficit in [gender] bilateral lower extremities. [Gender] does have difficulty with transfers and ambulation. [Gender] has to be fed by staff, otherwise, will not eat."

Review of the Nutrition CAA dated 7/3/13 revealed the following analysis of findings: "[Resident] was admitted to the LTCU [long term care unit] from acute care with generalized deconditioning, dehydration and malnutrition... has had a stroke... requires staff to feed [gender] or [gender] will not eat... has been put on Megace in addition to Remeron [both medications that can be used to stimulate the appetite] due to [gender] extremely poor nutritional status... is on a High Protein Regular diet with mighty shakes [a nutritional supplement] BT [between] meals and a 24 gm [gram] protein shake daily."

Review of the Pressure Ulcer CAA dated 7/3/13 revealed the following analysis of findings: "[Resident] is at high risk for pressure ulcer... scored 11 on the Norton scale [scoring system to predict pressure sore risk]... does require staff assistance for change of position... wears a brief for occasional urinary and stool incontinence."

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Review of the resident's care plan for pressure ulcers, last revised 7/9/13, revealed interventions directing staff to conduct a systematic skin inspection by a licensed nurse weekly, report skin abnormalities to the physician, CNA (certified nurse aide) to conduct weekly systematic skin inspection with the resident's bath, paying particular attention to the resident's bony prominences and report any abnormalities to the charge nurse, provide a high protein regular diet with mighty shakes between meals, provide a 24 gram protein shake daily, feed the resident, use absorbent, skin-friendly incontinence briefs to maintain personal hygiene and dignity, use moisture barrier to perianal area after each incontinent episode, and use a pressure relief cushion when in the wheelchair or recliner chair, and heel protectors while in bed and float heels (keep the resident's heels off of the surfaces) when in the wheelchair. The care plan lacked that the resident had a pressure ulcer at any time or any treatments that had been used during the time the pressure ulcer was open.

Review of the resident's laboratory (lab) section of the chart revealed a low albumin level of 3.3 g/dl (grams per decaliter) (normal range for an adult female 3.9-5.2 g/dl) on 6/18/13 and no further lab had been drawn.

Review of the Physician Progress Notes dated 6/28/13 revealed "Skin: SCRAPES AND SCABS ON RIGHT KNEE." No further skin issues had been identified.

Review of a "Medication Sheet" in the nurse treatment book dated July 2013 revealed an entry to "Monitor Pressure ulcer B/T [between] buttocks

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on R [right] side", but had not been signed off on at all during July.

Review of a Nutritional Assessment dated 7/17/13 revealed "Resident is new to LTC [long term care]. PO intake is 60% of meal which is fair. Skin is intact. Labs show ALB [albumin] noted low."

Review of the Weekly Skin Sheet dated 7/31/13 revealed the resident had a stage II pressure ulcer (a shallow open ulcer with partial thickness loss of the dermis layer of the skin) between the buttocks on the right side that measured 6 cm (centimeters) x 2 cm without drainage and the form identified it had been developed in house.

Review of a CNA weekly skin assessment dated 8/6/13 revealed the resident had a sore on his/her buttocks and sores on his/her right toes.

Review of the Skin/Wound Care Charting dated 8/18/13 at 7:15 a.m. revealed, "Area deep pink. 0 open noted."

Review of a "Medication Sheet" in the nurse treatment record book dated August 2013 revealed a sheet with an entry to "Monitor Pressure Ulcer to Buttocks." The pressure ulcer entry had been marked as "closed" on 8/25/13 and had not been initialed 6 times from 8/1/13 - 8/25/13.

Observation of direct care staff C on 9/4/13 at 10:49 a.m. revealed he/she took the resident to the bathroom, with the assistance of one other staff member and a gait belt. Staff assisted the resident to stand with the gait belt, cleaned the resident's peri-area after toileting, pulled the

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resident's pants up, and transferred the resident to the wheelchair with a chair pad approximately 2" thick in place. The resident's coccyx and buttock area was pink and without open areas.

Observation on 9/4/13 at 11:01 a.m. revealed direct care staff C and licensed nursing staff D assisted the resident from the wheelchair using a gait belt to stand and then used a pivot transfer to get the resident into his/her recliner and placed a chair alarm under the resident. The resident's wheelchair had a chair pad, but there was not any kind of chair cushion used in the resident's recliner. Staff clipped the resident's call light to his/her chair and put the button in his/her lap.

Observation on 9/4/13 at 12:17 p.m. revealed the resident sat in his/her recliner with the foot rest up, and direct care staff E sat on the arm of the resident's recliner and fed him/her. The resident ate 30% of the regular diet of meatloaf, seasoned potatoes, green beans, and cake and drank a small glass of grape juice (approximately 120 (ml) milliliters). The recliner did not have a chair cushion in place.

Observation on 9/5/13 at 9:16 a.m. revealed the resident sat in his/her recliner with the foot rest up without a chair cushion in place.

Interview with direct care staff C on 9/4/13 at 10:49 a.m., staff reported the resident required total assistance of two people for daily cares.

Interview with direct care staff C on 9/4/13 at 2:03 p.m. confirmed the resident did not have a chair cushion in the recliner, just a chair sensor pad.

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Interview with direct care staff C on 9/5/13 at 11:12 a.m. revealed the resident had previously had skin breakdown from being bony on his/her coccyx, but did not know if the nurses had considered it a pressure ulcer. Staff C reported when the resident had the open area, the CNAs had a sealant cream they put on it, and the nurses had a patch on the area for a while, but did not know if staff had done any other interventions they had done differently once the area opened. Staff C reported he/she repositioned the resident every two hours.

Interview with direct care staff G on 9/5/13 at 2:39 p.m. revealed the resident had previously had a place on his/her bottom that had a dressing on it and staff had put a sealant on it. Staff G revealed the area on the coccyx had been open, but he/she never saw it when the bandage was off of it. Staff G confirmed the resident did not have any open areas currently.

Interview with licensed nursing staff I on 9/5/13 at 12:50 p.m. revealed if a resident had a pressure ulcer, he/she expected the CNAs to offload the area. Staff I confirmed he/she would expect a pressure ulcer to be on the care plan.

Interview with licensed nursing staff H on 9/6/13 at 9:42 a.m. revealed pressure ulcers were measured weekly. Staff H reported when a pressure ulcer developed, the nurse who identified the wound initiated the wound protocol, then decided what kind of dressing the staff felt the wound needed, then notified the physician with recommendations based on the nurse's assessment and got orders for the care of the wound. Staff H reported for a stage I, staff usually did not use dressings. Staff H reported that the

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resident's pressure ulcer had been a stage I when he/she saw it, so staff did not use a dressing at that time.

Interview with administrative nursing staff A on 9/6/13 at 10:38 a.m. revealed when a pressure ulcer develops, he/she expected the staff to follow the policy and procedures for pressure ulcers, including notifying the physician. Staff A confirmed he/she would expect a pressure ulcer to be on the care plan.

Review of the facility policy for Wound Care, last revised 3/12, revealed "... Stage I Superficial Wound: ... Keep pressure off area, do not use donut devices, off load heels as needed ... Stage II Partial Thickness Wound: Goal: To maintain a moist wound environment, manage excess exudates. Remove or minimize cause. 1. Continue Stage I interventions."

The facility failed to update the resident's care plan when the resident developed a stage II pressure ulcer to the buttocks with any new interventions to heal the area and prevent further pressure sores.

- Review of resident #11's physician's orders sheet signed and dated on 7/24/13 revealed the resident had the following diagnosis: senile dementia (short and long term memory impairment).

Review of the annual MDS (minimum data set) dated 2/13/13 revealed the resident had short and long term memory loss with moderately impaired decision making ability. The resident

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required extensive assist of one staff for eating. The resident's height was 63 inches and weight was 185 pounds.

Review of the cognitive loss/dementia CAA (care area assessment) dated 2/14/13 revealed the resident was confused due to the diagnosis of senile dementia (short and long term memory impairment). The resident had short and long term memory impairment most of the time, was able to recognize familiar faces.

Review of the ADL (activities of daily living) CAA dated 2/14/13 revealed the resident was alert, confused, and required staff assistance for all of his/her eating.

Review of the nutritional CAA dated 2/14/13 revealed the resident was on a regular NAS (no added salt diet). The resident sat at the assisted dining table. The resident had a plate guard, and staff assisted to cut up his/her food. The resident consumed 75-100% of the meals and his/her weight was stable. The resident was able to communicate his/her wants and needs to staff.

Review of the Quarterly assessment dated 8/20/13 revealed the resident had short and long term memory impairment with moderately impaired decision making abilities. The resident required extensive assist of one staff member for eating. The resident's height was 63 inches and weight was 185 pounds.

Review of resident #11's care plan dated 2/4/13 and reviewed on 5/20/13 revealed the resident was at risk for nutritional deficits and received a therapeutic diet. The resident's current weight was 175 pounds and stable. The care plan

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directed the staff to administer the resident's medication per the physician's orders, encourage the resident to drink fluids, offer fluids with each episode of care, ensure the wooden board table is placed on my table when I am in the dining room to put my food and drinks on to eat independently. A care plan update on 5/29/13 revealed the resident may use a bedside table to aid in eating his/her meals. A care plan update on 5/30/13 revealed the resident may need more assistance of the staff now related to decline, honor the resident's right to refuse food and fluids, monitor the resident's legs for swelling, provide the resident with a regular NAS (no added salt) diet to decrease retention of fluids, weigh the resident at least weekly during his/her bath. and report my significant changes to the resident's physician per the protocol. A care plan update on 8/20/13 revealed the resident's current weight was 157 pounds.

Review of the resident's weight record revealed:

February 2013 - 186 pounds
March 2013 - 186 pounds
April 2013 - 174 pounds (a severe weight loss of 6.4 % in 1 month)
May 2013 - 175 pounds
June 2013 - 176 pounds
July 2013 - 166 pounds (5.6 % weight loss in 1 month)
August - 157 pounds ( a severe weight loss of 15.59 % in 6 months)

The facility failed to provide a policy in regard to the revision of comprehensive care plans as requested on 9/6/13

The facility failed to revise the resident's

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comprehensive care plan to reflect the significant weight loss for resident #11.

- Review of resident #11's annual MDS (minimum data set) dated 2/13/13. The resident was dependent on staff for bed mobility, transfers, locomotion,dressing, and toilet use. The resident required extensive assist of one staff for personal hygiene, eating and bathing. The resident had one non - injury fall since the last assessment. The resident was dependent on staff for all other aspects of his/her ADLs.

Review of the nutritional CAA dated 2/14/13 revealed the resident was on a regular NAS (no added salt diet). The resident sat at the assisted dining table. The resident had a plate guard, and staff cut up his/her food. The resident consumed 75-100% the meals and his/her weight was stable. The resident was able to communicate his/.her wants and need to staff.

Review of the Fall CAA dated 2/14/13 revealed the resident was at risk falls and had one fall this past quarter, prior to that fall it had been almost a year since the resident's last fall. Review of that incident revealed the resident's roommate observed him/her attempting to get out of bed on his/her own and slid to the floor without injury.

Review of the care plan dated 5/20/13 revealed the resident was at risk for falls. The care plan directed the staff to assess the resident for the cause of falls, complete post fall monitoring per the LTCU (long term care unit) protocol, complete a fall risk assessment quarterly and PRN (as needed).

Review of the care plan updated on 3/25/13

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revealed the addition of a fall mat on floor next to bed.

Review of the care plan update on 5/10/13 revealed resume non-skid adhesive to the rock in go chair while the resident was up.

Review of the care plan updated on 5/20/13 revealed the resident received a new rock and go

Review of the care plan updated on 6/5/13 revealed left side of resident bed turned against the wall continue to place fall mat to the other side of the bed.

Review of the Fall Risk Assessment dated 5/20/13 revealed a score of 19 (high risk for falls).
Review of the Radiology report dated 6/9/13 revealed multiple rib fractures.
On 9/6/13 at 3:03 p.m. an interview with Administrative nurse B revealed the facility required the care plan to be updated with each change in the resident status to reflect to most current plan of care. Staff B confirmed the facility failed to identify effective interventions to reduce the resident risk for falls and injuries related to falls.

The facility failed to provide a policy in regard to the revision of comprehensive care plans as requested on 9/6/13.

- Review of resident #30's closed medical record revealed an admission MDS (minimum date set) assessment dated 4/17/13 with a BIMS (brief interview for mental status) score of 10 (moderately impaired cognitive status). The resident required set up help with meals.
Review of the resident's ADLs (activities of daily

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living) CAA dated 4/17/13 (care area assessment) revealed the resident was admitted from another facility related to the need for treatment of lung cancer. The resident received radiation and chemotherapy 5 days per week. The resident received a low salt, low carbohydrate diet. The resident ate independently and averaged a daily intake of 79% for breakfast and lunch and 91 % for supper. The resident had candy in the room that he/she snacked on. The resident took multiple snacks from the snack cart when offered. The resident had his/her own teeth and denied pain related to his/her teeth. The resident gained approximately 6 pounds since admission. The resident received chemotherapy and radiation 5 days per week and denied nausea or vomiting related to treatment at the time of the assessment.

Review of the resident's nutrition care plan dated 4/4/13 and last reviewed on 5/29/13 revealed the resident required a low carbohydrate and low fat therapeutic diet. The care plan directed the staff to provide the resident with protein, such as peanuts and milk, praise the resident when he/she had good dietary compliance, provide the resident with late night food tray, and provide the resident with as much control as possible in choosing his/her food.

Review of the care plan update on 5/20/13 revealed the resident had began refusing most meals and fluids. The resident drank a few sips of lemonade. The care plan directed the staff to offer the resident anything he/she would like. Another care plan entry dated 5/20/13 revealed the resident had significant weight loss related to his/her refusal of foods and fluids. The care plan directed the staff to offer the resident fluids

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frequently and encourage small bits of food, likes peanuts and sweets.

Review of the care plan update on 5/29/13 revealed a significant weight loss in one month. The resident had chosen not to eat or drink. The resident would occasionally request Pepsi or lemonade. The resident reported he/she was not hungry, did not care, and was weak and tired.

Review of the resident's weight history revealed the following:

4/4/13 - 240 pounds
4/22/13 - 240 pounds
5/1/13 - 221 pounds
5/17/13 - 222.5 pounds
5/25/13 - 220.6 pounds 8.08% weight loss in 30 days (from 4/22/13 to 5/25/13)

On 9/6/13 at 3:03 p.m. an interview with Administrative nurse B revealed the facility required the care plan to be updated with each change in the resident status to reflect to most current plan of care. Staff B confirmed the facility failed to update the resident care plan after the identification of the resident significant weight loss on 5/25/13.

The facility failed to provide a policy in regard to the revision of comprehensive care plans as requested on 9/6/13

The facility failed to implement new intervention revise the resident's comprehensive care plan to reflect the significant weight loss and the development of two stage 2 pressure ulcers for resident #30.

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- Review of resident #30's closed medical record revealed an admission MDS (minimum date set) dated 4/17/13 with a BIMS (brief interview for mental status) score of 10 (moderately impaired cognitive status). The resident required limited assistance of one staff member for ambulation, toilet use, and personal hygiene. He/she required extensive assist of one staff member for locomotion and bathing and required set up help and supervision with dressing. The resident required set up help with meals. The resident height was 61 inches and the resident's weight was recorded as 233 pounds. The resident received a therapeutic diet. The MDS revealed the resident had a pressure relieving device to his/her bed and chair with no skin breakdown.

Review of the resident's ADLs (activities of daily living) CAA (care area assessment) dated 4/17/13 revealed the resident was admitted from another facility related to the need for treatment of lung cancer. The resident received radiation and chemotherapy 5 days per week. The resident received a low salt, low carbohydrate diet related to his/her past history of renal disease and insulin dependant diabetes mellitus. The resident ate independently and averaged a daily intake of 79% for breakfast and lunch and 91% for supper. The resident had candy in the room that he/she snacked on. The resident took multiple snacks from the snack cart when offered. The resident gained approximately 6 pounds since admission. The resident received chemotherapy and radiation 5 days per week and denied nausea or vomiting related to treatment at the time of the assessment.

Review of the resident's CAA (care area assessment) revealed the resident did not trigger

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for pressure ulcers.

Review of the resident's care plan dated 5/20/13 revealed the resident was at risk for skin break down related to weight loss, increased urinary incontinence and lack of mobility. The care plan directed the staff to ensure the call light was present and in reach, check for incontinence at least every 2 hours, provide incontinence care with barrier cream as needed, provide briefs for dignity, weekly skin assessment to check for breaks in skin, and encourage the resident to change position from recliner to bed and lay on his/her side.

Review of the resident's lab dated 5/21/13 revealed a low albumin (amount of protein in the blood) level of 2.5 (normal range 3.4 - 5.4) gm/dl (grams per deciliter) and a total protein (the total amount of two classes of protein in the blood) level of 5.3 gm/dl (normal range 6.0 - 8.3 gm/dl). The lab results revealed the resident was malnourished.

Review of the Weekly Skin Assessment sheet dated 6/2/13 revealed a 0.75 cm length x 0.75 cm width stage 2 pressure ulcer (open wound formed from prolonged pressure) to the right side of the resident's coccyx.

On 9/6/13 at 3:03 p.m. an interview with Administrative Staff B confirmed the facility failed to implement new interventions and update the resident care plan after the identification of two stage 2 pressure ulcers on 5/21/13.

The facility failed to provide a policy in regard to the revision of comprehensive care plans as requested on 9/6/13.

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The facility failed to implement new intervention and revise the resident comprehensive care plan to reflect the development of two stage 2 pressure ulcers for resident #30

- Review of resident #5's annual MDS (minimum data set) dated 11/6/12 revealed a BIMS (brief interview for mental status) with a score of 5 (severely impaired). The functional status revealed the resident needed extensive assistance of one person for eating. No documentation of weight loss or gain was found on the assessment. The resident was 60 inches tall and weighed 173 pounds.

Review of the quarterly MDS dated 7/13/13 indicated the staff assessed the resident for mental impairment and the resident was moderately impaired. The functional status revealed the resident was totally dependent on 1 staff for eating. The assessment indicated the resident had no weight loss or gain and received a mechanically altered diet.

Review of the Nutrition CAA (care area assessment) dated 11/6/12 revealed it did not trigger.

Review of the care plan with a date of 1/30/13 revealed a problem with Nutritional status. The staff were to assist the resident with eating as allowed or as requested. Remind the resident to eat slowly and take small bites. Use a colored lip plate and other adaptive devices as needed. The resident was to receive nectar thick liquids at all times. The facility did not update the care plan with the continued weight loss that occurred between 1/13 to 5/13. No further interventions on

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the care plan. The resident had a total weight loss of 29 pounds during the time.

On the care plan, revision dated 5/12/13 the resident had a 14.9% (percent) weight loss in 6 months. Begin Breeze (a dietary supplement) 2 times daily. No mention was made on the care plan the amount to give or who was responsible for giving the supplement. The staff were to assess the amount of supplement taken prior to documenting the percentage in the MAR (medication administration record). Staff made no other changes to the care plan for the continued weight loss from 5/13 to 8/13.

On 9/5/13 review of the direct care staff pocket sheet, indicated that the resident needed assistance with eating. Staff were to encourage the resident to do what he/she could for him/herself. Resident required thickened liquids and assistance for eating.

There was no documentation in the resident record of additional interventions from the 1/13 (first significant weight loss) and 3/1/13 (2nd significant weight loss) until 5/12/13 (order for Boost). No changes on the care plan for the weight loss.

Review of the Dietary progress note dated 2/4/13, revealed the resident received a regular diet with soft with finger foods (not on the care plan). The resident would benefit from verbal encouragement to eat protein rich foods and drink. PLAN: Recommend the staff to encourage the resident to eat protein rich foods and monitor.

Review of the dietary progress notes dated 5/8/13, revealed the resident's oral intake was fair

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at 50 %. The resident would benefit from verbal encouragement to eat protein rich foods and drink. PLAN: encourage the resident to eat protein rich food, drink fluids and monitor.

Review of the dietary progress notes dated 8/7/13 revealed the residents oral intake was poor at 53%. PLAN: Recommend staff encourage the resident to eat protein rich food, drink fluids monitor and follow the resident.

On 9/6/13 review of the meal intake sheets for June, July and August 2013 revealed that the resident ate an average of 50 %.

On 9/4/13 at 11:25 a.m., one staff member assisted the resident to eat the meal. The resident had meatloaf, potatoes, green beans, Jell-O. Thickened orange drink, soda and water, all fluids served in 240 ml glasses.

On 9/6/13 at 3:00 p.m., administrative nursing staff B revealed that the care plans for weight loss and pressure ulcers were updated by him/her.

On 9/5/13 at 5:25 p.m., administrative nursing staff A revealed the resident had a significant weight loss in from 9/12 to 3/13.

On 9/6/13 at 9:22 a.m., administrative nursing staff A revealed that the program for monitoring weight loss was not fine-tuned yet. When asked how long the resident continued on the same intervention especially those interventions that are not effective, before changing it. He/she replied that the intervention was tried about 1 month. The intervention of Boost started in 5/13. Weight loss continued with no care plan changes

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made.

The facility failed to ensure the care plan was updated with interventions to guide staff on the care of resident #5 with ongoing weight loss.

- Review of resident #17's admission MDS (minimum data set) dated 2/1/13 revealed a BIMS (brief interview for mental status) with a score of 10 (moderately impaired). The resident's functional status revealed that the resident was independent with bed mobility and required limited assist of 1 person to transfer, walk in room, dress and toilet. Review of the resident's falls since admission revealed the resident had 2 or more non-injury and 1 injury fall.

Review of the quarterly MDS dated 7/31/13 revealed a BIMS of 8 (moderately impaired). The functional status of the resident was independent and no assistance with bed mobility, transfers, walking, limited assist of 1 for dressing and supervision and no assist for toileting. The residents' fall history on admission revealed the resident had falls in the last month and falls in the last 2-6 months no fractures

Review of the Activity of Daily Living CAA (care area assessment) dated 2/5/13 revealed a significant decline in functional status following the recent hospitalization. The resident declined also in strength, as well as mentation. Endurance is fair and transferred sit to stand independently. The standing balance was fair without support. The resident ambulated with front wheeled walker and 1 staff for safety.

Review of the Fall CAA dated 2/5/13 revealed the

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resident had a history of falls at home 1/2011 due to use of Flexeril (muscle relaxer) for cervical neck pain/arthritis and severe degenerative arthritis. The resident had fallen 3 times since admission with minor injury. The resident also bent to pick things up went to the bathroom alone. Remind the resident not to ambulate in stocking feet.

Review of the care plan with a date of 2/5/13 revealed the following problems: Falls, complete quarterly fall risk assessment and PRN (as needed) complete post fall monitoring per LTC (long term care) facility protocol. Assume standing position slowly, assure the resident has pressure alarm on the bed and is turned on and working. On 5/24/13, remind not to ambulate in stocking feet. On 8/18/13, remind resident the importance of using the call light. On 8/21/13, remind to call for assist. On 8/21/13 make, sure alarms are on and in place. Resident family has purchased a black and yellow gait belt the "tool belt" resident accepts that easier. The resident continued to ambulate to and from meals and activities with walker and 1 assist. The resident refused assistance while walking. The care plan did not address close monitoring and observation of the resident by the staff. The care plan did not match what the 8/8/13 Fall Physical Assessment form that planned for the resident, interventions such as every 30 minute visual checks. The care plan did not address the treatment and care for the multiple skin tears from the falls dated 8/18/13 at 4:00 p.m.

Review of the Fall Physical Assessment form dated 8/8/13 at 3:45 p.m., revealed the resident got his/her feet tangled in the covers. No call light sounded, and the resident was sitting on the floor

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next to the bed alarm, that did not sound. Initiation of special monitoring sheets with documentation every 30 minutes on the resident and visual check made and initialed for the checks.

Review of the Fall Physical Assessment form dated 8/18/13 at 4:00 p.m., revealed the resident returned to the facility from an outing with the family. The family lowered the resident to the floor after losing balance. The resident had abrasions to the right palm and right elbow. The resident also suffered a skin tear to the right forearm measuring 0.5 x 0.5 cm (centimeters) and outer elbow 7 x 5 cm and 2 x 2 cm to inner elbow left upper right elbow 3 x 3 cm. The resident reported trying to open his/her door and lost balance. Resident to use the call light for assist for ambulation and transfers in his/her room with gait belt and walker. No care plan update for the treatment of the skin tears.

Review of the Fall Physical Assessment form 8/21/13 at 4:00 p.m., revealed an un-witnessed fall while the resident was going back to bed. The resident went to the bathroom and slid off the side of the bed to the floor and onto his/her the knees. The resident had an abrasion to the knees. Intervention; nonskid socks, alarms, call light and reorientation to call for help. These interventions were not care planned.

Review of the Fall Physical Assessment form 8/26/13 at 09:30 p.m., revealed the resident was bearing down on the toilet and got light headed and the aide lowered him/her to the floor abrasions noted to the right hand knuckle and left clavicle. Interventions; assistance of 2 staff.

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Review of the direct care pocket sheets and the care plan reveal no mention of the 30 minute checks. There was no documentation of the staff doing the 30 minute checks, from the Fall Physical Assessment form dated on 8/8/13. Staff failed to check the condition and the whereabouts of the resident every 30 minutes.

On 9/4/13 at 11:30 a.m., the resident ambulated to the dining room with walker, gait belt, and the family member.

On 9/4/13 at 2:10 p.m., direct care staff J and K reported that the resident required assistance of 1 person. Then the resident fell and got the skin tears and now needs more assistance than before. The resident could use the call light, get up, and walk so when the staff came in to the room staff took him/her to the bathroom. The resident continued to turn off the alarm by him/herself.

On 9/5/13 at 2:30 p.m. direct care staff J reported that the direct care staff book had the (care plan) pocket sheet for all the staff and new employees and agency. This resident plan on the pocket sheet indicated that he/she was using the alarm and used the walker sometimes he/she was more confused than others. The resident was a fall risk, and had pressure alarm on the bed. The staff must check on him/her at night. The resident must have stand by assistance when ambulating. The staff did not check this resident on a regular basis. The area for the 30 minute checks was not marked. Direct care staff J reported that he/she was not sure why the staff were not doing checks on this resident.

On 9/5/13 at 4:09 p.m., direct care staff L

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| F 280 | Continued From page 28<br>reported that the resident had a pressure pad under him/her. The resident was not as dependent as he/she wanted to be due to being more unsteady on his/her feet.<br><br>The facility failed to ensure that the resident's care plan updated with the interventions to guide the staff in the care and treatment of the wound care for the skin tears. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility census totaled 33 with 18 residents included in the sample. Based on observation, interview, and record review, the facility failed to follow the standing orders for wound care or obtain an order for a wound dressing for 1 of 3 residents reviewed for skin conditions. (#17)<br><br>Findings included:<br><br>- Review of resident #17's admission MDS (minimum data set) dated revealed a BIMS (brief interview for mental status) score of 10, indicating moderate cognitive impairment. The residents functional status revealed that the resident was independent with bed mobility, but | F 309 | | |

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required limited assistance of one person for transfers, walking in the room, dressing, and toileting. The resident did not have any skin problems.

Review of the quarterly MDS dated 7/31/13 revealed a BIMS score of 8, indicating moderate cognitive impairment. The resident's functional status assessment revealed the resident was independent for bed mobility, and limited assistance of one for transfers, walking, and supervision for dressing and toileting. The resident had a history of falls on admission. The resident had skin tears and treatments of ointments for an area other than his/her feet.

Review of the pressure ulcer CAA (care area assessment) dated revealed the resident was at risk for pressure ulcers, but did not have any breakdown. The CAA did not mention any skin tears.

Review of the resident's comprehensive care plan revealed it lacked any skin conditions and interventions for the resident.

Review of a weekly skin assessment dated 8/27/13 revealed numerous bruises noted on the resident's arms and torso with steri-strips in place to the left upper arm on a skin tear. The resident's left upper arm, right upper arm and right hand had bandages.

Review of the facility's standing orders for skin tears revealed orders for steri-strips and triple antibiotic ointment for skin tears. The orders did not include occlusive dressings except on decubitus ulcers.

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Review of the treatment administration record dated 9/3/13 revealed both forearms had Tegaderm (occlusive dressing) dressings in place. The nurse had assessed the resident's arms and the areas did not have drainage and the Tegaderm were intact bilaterally (both arms).

Review of the treatment administration record dated 9/4/13 revealed a small amount of drainage from the bilateral skin tears was noted and the Tegaderm remained intact.

Review of a nurses note dated 8/27/13 revealed the resident got up in the room without using his/her call light to call for assistance. The staff assisted the resident to the bathroom and back to the recliner. Staff attached the resident's call light to the recliner and reminded the resident to use the call light to call for assistance. The staff turned the chair pad alarm on, as before when he/she got up with out assistance.

Review of a nurses note dated 9/4/13 revealed the resident got up to the bathroom twice during the shift with out calling for assistance. The chair pad alarm sounded and the resident was reminded to call for assistance.

Observation on 9/3/13 at 2:49 p.m. revealed the resident had skin tears to bilateral forearms.

Observation on 9/4/13 2:00 p.m. revealed the resident sat in a recliner and had his/her feet up. The resident had a clear plastic dressing over skin tears on both forearms and upper arms.

Observation on 9/5/13 at 10:00 a.m. the resident continued to have multiple areas on his/her forearms and upper arms that were visible when

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the resident wore a short-sleeved shirt. The skin tears were covered with clear plastic dressings.

Observation on 9/5/13 at 4:30 p.m. revealed no change to the dressings to the resident's arms.

During an interview on 9/4/13 at 11:06 a.m., the resident reported the skin tears happened a long time ago when he/she fell, but did not cause pain.

Interview on 9/5/13 at 4:09 p.m. with direct care staff L revealed the resident just bumped into things, and his/her skin just disintegrated. Staff L reported the staff tried to be careful with the resident's skin.

Interview on 9/5/13 at 1:04 p.m. with licensed nursing staff I revealed skin tears were treated based on nursing discretion. Staff I reported the staff were careful with the resident's skin due to the skin tears. Staff I confirmed there were no orders for the Tegaderm or occlusive dressing but if a resident needed a specific treatment, then the nurse needed an order that should be documented in the treatment book.

During an interview on 9/5/13 at 4:53 p.m., licensed nursing staff M reported the resident's skin tears were caused by underlying medical conditions and the resident took a lot of prednisone (a steroid medication) and blood thinners. Staff M also reported the resident sustained some skin tears from falls and some from bumping into things,

Interview on 9/5/13 at 4:55 p.m. with administrative nursing staff A confirmed the wound care protocol contained an order for steri-strips and for any other dressing the nurse

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needed to get an order.

Interview on 9/5/13 at 4:55 p.m. with administrative nursing staff B revealed the standing orders for transparent dressing were for decubitus ulcers and confirmed the skin tears were not included in the order for transparent dressing use.

Interview on 9/6/13 at 10:06 a.m. with administrative nursing staff A confirmed there was not an order for a treatment for the resident's skin tears and there were occlusive Tegaderm dressings on the resident's arms.

POLICY

The facility failed to obtain and implement appropriate treatment orders for the resident's multiple skin tears.

The facility census totaled 33 with 18 residents included in the sample. Based on observation, interview, and record review, the facility failed to follow the standing orders for wound care or obtain an order for a wound dressing for 1 of 3 residents reviewed for skin conditions. (#17)

Findings included:

- Review of resident #17's admission MDS (minimum data set) dated 2/1/13 revealed a BIMS (brief interview for mental status) score of 10, indicating moderate cognitive impairment. The residents functional status revealed that the resident was independent with bed mobility, but required limited assistance of one person for transfers, walking in the room, dressing, and

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toileting. The resident did not have any skin problems.

Review of the quarterly MDS dated 7/31/13 revealed a BIMS score of 8, indicating moderate cognitive impairment. The resident's functional status assessment revealed the resident was independent for bed mobility, and limited assistance of one for transfers, walking, and supervision for dressing and toileting. The resident had a history of falls on admission. The resident had skin tears and treatments of ointments for an area other than his/her feet.

Review of the pressure ulcer CAA (care area assessment) dated 2/6/13 revealed the resident was at risk for pressure ulcers, but did not have any breakdown. The CAA did not mention any skin tears.

Review of the resident's comprehensive care plan revealed it lacked any skin conditions and interventions for the resident.

Review of a weekly skin assessment dated 8/27/13 revealed numerous bruises noted on the resident's arms and torso with steri-strips in place to the left upper arm on a skin tear. The resident's left upper arm, right upper arm and right hand had bandages.

Review of the facility's standing orders for skin tears revealed orders for steri-strips and triple antibiotic ointment for skin tears. The orders did not include occlusive dressings except on decubitus ulcers.

Review of the treatment administration record dated 9/3/13 revealed both forearms had

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Tegaderm (occlusive dressing) dressings in place. The nurse had assessed the resident's arms and the areas did not have drainage and the Tegaderm were intact bilaterally (both arms).

Review of the treatment administration record dated 9/4/13 revealed a small amount of drainage from the bilateral skin tears was noted and the Tegaderm remained intact.

Review of a nurses note dated 8/27/13 revealed the resident got up in the room without using his/her call light to call for assistance. The staff assisted the resident to the bathroom and back to the recliner. Staff attached the resident's call light to the recliner and reminded the resident to use the call light to call for assistance. The staff turned the chair pad alarm on, as before when he/she got up with out assistance.

Review of a nurses note dated 9/4/13 revealed the resident got up to the bathroom twice during the shift with out calling for assistance. The chair pad alarm sounded and the resident was reminded to call for assistance.

Observation on 9/3/13 at 2:49 p.m. revealed the resident had skin tears to bilateral forearms.

Observation on 9/4/13 2:00 p.m. revealed the resident sat in a recliner and had his/her feet up. The resident had a clear plastic dressing over skin tears on both forearms and upper arms.

Observation on 9/5/13 at 10:00 a.m. the resident continued to have multiple areas on his/her forearms and upper arms that were visible when the resident wore a short-sleeved shirt. The skin tears were covered with clear plastic dressings.

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Observation on 9/5/13 at 4:30 p.m. revealed no change to the dressings to the resident's arms.

During an interview on 9/4/13 at 11:06 a.m., the resident reported the skin tears happened a long time ago when he/she fell, but did not cause pain.

Interview on 9/5/13 at 4:09 p.m. with direct care staff L revealed the resident just bumped into things, and his/her skin just disintegrated. Staff L reported the staff tried to be careful with the resident's skin.

Interview on 9/5/13 at 1:04 p.m. with licensed nursing staff I revealed skin tears were treated based on nursing discretion. Staff I reported the staff were careful with the resident's skin due to the skin tears. Staff I confirmed there were no orders for the Tegaderm or occlusive dressing but if a resident needed a specific treatment, then the nurse needed an order that should be documented in the treatment book.

During an interview on 9/5/13 at 4:53 p.m., licensed nursing staff M reported the resident's skin tears were caused by underlying medical conditions and the resident took a lot of prednisone (a steroid medication) and blood thinners. Staff M also reported the resident sustained some skin tears from falls and some from bumping into things,

Interview on 9/5/13 at 4:55 p.m. with administrative nursing staff A confirmed the wound care protocol contained an order for steri-strips and for any other dressing the nurse needed to get an order.

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| F 309 | Continued From page 36<br>Interview on 9/5/13 at 4:55 p.m. with administrative nursing staff B revealed the standing orders for transparent dressing were for decubitus ulcers and confirmed the skin tears were not included in the order for transparent dressing use.<br><br>Interview on 9/6/13 at 10:06 a.m. with administrative nursing staff A confirmed there was not an order for a treatment for the resident's skin tears and there were occlusive Tegaderm dressings on the resident's arms.<br><br>Review of the facility policy for Wound Care Policy dated 07/00 and revised on 2/11.<br><br>SKIN TEARS:<br><br>Goal : To approximate wound edges and treat to facilitate healing wound without infection.<br>1. Cleanse wound and apply steri strips per standing order<br>2. Apply Triple antibiotic ointment<br>3. Contact physician if further treatment is needed<br>6. Care Plan interventions and update the care plan<br><br>The facility failed to obtain and implement appropriate treatment orders for the resident's multiple skin tears. | F 309 | | |
| F 314 SS=G | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores | F 314 | | |

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does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 33 with 18 residents included in the sample. Of the 18 sampled, 2 residents were reviewed for pressure ulcers. Based on observation, interview and record review, the facility failed to develop and implement preventative measures to reduce the risk for and development of avoidable pressure ulcers for 2 of 2 residents. (#28,#30).

Findings included:

- Review of resident #30's closed medical record revealed an admission MDS (minimum data set) dated 4/17/13 with a BIMS (brief interview for mental status) score of 10 (moderately impaired cognition). The resident required limited assistance of one staff member for ambulation, toilet use, and personal hygiene. The resident required set up help with meals. The resident's weight was 233 pounds. The resident received a therapeutic diet. The MDS revealed the resident had a pressure relieving device to his/her bed and chair with no skin breakdown.

Review of the resident's ADLs (activities of daily living) CAA (care area assessment) revealed the resident admitted from another facility related to the need for treatment of lung cancer. The resident received radiation and chemotherapy 5

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days per week. The resident received a low salt, low carbohydrate diet related to his/her past history of renal (kidney) disease and insulin dependant diabetes mellitus. The resident ate independently and averaged a daily intake of 79% for breakfast and lunch and 91 % for supper. The resident had candy in the room that he/she snacked on. The resident took multiple snacks from the snack cart when offered. The resident gained approximately 6 pounds since admission. The resident received chemotherapy and radiation 5 days per week and denied nausea or vomiting related to treatment at the time of the assessment.

The Pressure Ulcer CAA (care area assessment) did not trigger.

Review of the resident's care plan dated 5/20/13 revealed the resident was at risk for skin break down related to weight loss, increased urinary incontinence and lack of mobility. The care plan directed the staff to ensure the call light was present and in reach, check for incontinence at least every 2 hours, provide incontinence care with barrier cream as needed, provide briefs for dignity, weekly licensed skin assessment to check for breaks in skin, and encourage the resident to change position from recliner to bed and lay on his/her side.

Review of the resident's lab dated 5/21/13 revealed a low albumin (amount of protein in the blood) level of 2.5 (normal range 3.4 - 5.4) gm/dl (grams per deciliter) and a total protein (the total amount of two classes of protein in the blood) level of 5.3 gm/dl (normal range 6.0 - 8.3 gm/dl). The lab results revealed the resident was malnourished.

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Review of the nurses notes dated 5/12/13 at 10:30 p.m. revealed the resident's buttocks were reddened. The resident complained of soreness to the area. The resident was encouraged to lay in bed to relieve pressure to his/her buttocks, and the resident refused. The same note revealed no evidence that staff provided education to the resident regarding his/her failure to comply with position changes.

Review of the nurses notes dated 5/13/13 at 9:00 p.m. revealed the resident continued to complain of pain to his/her buttocks. The buttocks was reddened. The resident was encouraged to lay in bed unsuccessfully. The same note revealed no evidence that staff provided the resident with education regarding his/her failure to comply with position changes.

Review of the admission skin assessment dated 4/4/13 revealed the resident had no skin breakdown.

Review of the Weekly Skin Assessment sheet dated 5/16/13 revealed the resident had reddened areas that remained after 30 minutes of pressure reduction to his/her bottom.

Review of the CNA (certified nursing assistant) Weekly Skin Assessment sheets dated 5/30/13 revealed the resident had "galled" areas to the buttock. The CNA documented Selan (a moisture barrier cream) was applied to the area.

Review of the Weekly Skin Assessment sheet dated 6/2/13 revealed a 0.75 cm length x 0.75 cm width stage 2 pressure ulcer (open wound formed

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from prolonged pressure) to the right side of the resident's coccyx.

Review of the Weekly Skin Assessment sheet dated 6/4/13 revealed the resident had 0.3 cm stage 2, and a 0.6 cm stage 2 pressure ulcer to the right buttocks.

Review of the Interdisciplinary Progress Note dated 6/2/13 at 8:45 p.m. revealed the resident had a stage 2 pressure ulcer on the right side of his/her coccyx. Staff cleansed the area and covered with Allevyn (wound care dressing).

Review of the Interdisciplinary Progress Note dated 6/3/13 at 2:00 p.m. revealed a 0.5 cm (centimeter) open area on the right and left buttock cheeks. Staff cleansed the area and covered with Allevyn thin. The progress note also revealed the resident had a 2 cm open area to the genital area.

Review of the Nurses Notes and the Interdisciplinary Progress notes for May and June 2013 revealed the facility failed to notify the physician of the resident's development of two stage 2 pressure ulcers to his/her buttocks and the 2 cm open area to the genital area.

Review of the physician's standing orders sheet revealed for a stage 2 pressure ulcer the facility may use an occlusive dressing (a material used for covering and protecting wounds).

Review of the physician's orders sheets revealed no notation that staff initiated the standing order for treatment with an occlusive dressing.

Review of the dietician notes dated 4/23/13

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revealed a new recommendation of 2 ounces of extra protein with meals and high protein snacks TID (three times daily). The note also revealed the dietician would monitor and follow the resident.

The facility was unable to provide any documentation that the high protein snacks, 2 ounces of extra protein with meals or the fourth meal tray was provided or consumed by the resident.

Review of the Standing orders for Wound Care recommended by the Registered Dietician revealed the following:

Stage 1 pressure ulcer

Multiple vitamin/mineral at breakfast
Zinc sulfate 220 mg (milligrams) at morning med pass
Vitamin C 500 mg at lunch
Arginaid (used to aid in wound healing) packet mixed in 4 ounces of water (mixed until dissolved) at noon meal
Document amount consumed

Stage 2 to 3 pressure ulcer

Multiple vitamin at breakfast
Zinc Sulfate 220 mg at morning and evening med pass
Vitamin C 500 mg at lunch and supper
Arginaid (used to aide in wound healing) packed mixed in 4 ounces of water (mixed until dissolved) at breakfast and noon meal
Document amount consumed.

Review of the resident's May 2013 and June

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2013 MAR (medication administration sheet) and TAR (treatment administration record) revealed the facility failed to initiate the standing orders for wound treatment supplementation as recommended by the registered dietician and ordered by the physician.

Further review of resident #30's record revealed the resident was only seen by the dietician for the pintail visit on 4/23/13 until his/her discharge from the facility on 6/4/13.

Review of the Norton skin assessment form dated 4/4/13 and 4/17/13 revealed a score of 22. (low risk for skin breakdown)

Review of the Norton skin assessment form dated 5/29/13 revealed a score of 12 (high risk for pressure ulcers).

On 9/5/13 at 1:42 p.m. Licensed nurse I revealed the resident was able to turn and reposition him/herself and was continent of bowel and bladder upon admission to the facility. Staff I revealed the resident ate well including an extra meal in the evening and snacks. Staff I revealed the resident declined and became dependent for meals and incontinence care. Further interview with staff I revealed when the resident developed a pressure area the staff nurses were expected to call or fax the doctor of the skin breakdown and to obtain orders for treatment. The treatment was to be recorded on the resident treatment sheets and signed by the nurse completing the wound care per the physician's orders.

On 9/5/13 at 1:02 p.m. an interview with Licensed nurse P revealed the resident was difficult, refused almost all food and assistance with

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ADLs. Staff P revealed the resident had stage 2 pressure ulcers that developed in the facility to his/her buttocks at the time of his/her discharge related to incontinence, the inability to reposition him/herself and the resident refused incontinence care at times.

On 9/5/13 at 2:00 p.m. an interview with Administrative nurse A revealed the resident had a significant weight loss and developed two stage 2 decubitus ulcers while in the facility. Staff A's expectation of the facility staff was to follow the standing orders for weight loss and skin breakdown for the facility and all orders for treatment to wounds should be placed on the TAR (treatment administration record) and supplements to aid in weight management and wound healing should be placed on the MAR (medication administration record). Staff A confirmed the staff failed to initiate the standing orders for the weight loss and the development of the pressure ulcers and failed to obtain physician's orders for the treatment of the pressure ulcers. Staff A revealed the registered dietician should have reviewed the resident at least monthly with the significant weight loss and the development of the pressure ulcers. Staff A confirmed the facility failed to have the registered dietician review the resident for possible interventions to aid in weight loss and the treatment of pressure ulcers. Further interview with Administrative staff A confirmed the facility was unable to provide any documentation of the high protein snacks and the fourth meal tray being provided to the resident as recommended by the dietician.

On 9/11/13 at 12:35 p.m. an interview with Dietary consultant O revealed each resident was

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seen up admission to the facility for a nutritional evaluation. Staff O revealed residents were then seen at least quarterly for re-evaluation of their nutritional needs. Staff O revealed residents with renal concerns, weight loss and wounds were reviewed monthly and as needed. Consultant O revealed he/she the facility was responsible for notification of the changes to him/her to ensure the resident had his/her nutritional needs and interventions reviewed for possible changes. Staff O confirmed he/she was unaware of the significant weight loss and development of two stage 2 pressure ulcers of the resident's nutritional needs and supplements would have been reviewed in May 2013. Staff O confirmed that all standing orders for nutritional interventions for weight loss and pressure ulcers were to be placed on the MAR with signatures and percentage of the supplements taken.

On 9/11/13 at 2:12 p.m. an interview with Physician R revealed the resident had stage 3 lung cancer and transferred to the facility to have access to chemotherapy and radiation treatments. The resident refused medications, meals, and personal care. Physician R revealed he/she was aware that the resident had lost weight during his/her stay at the facility. Staff R revealed he/she was not certain he/she was aware the weight loss was significant. Staff R revealed his/her progress notes did not address the resident's significant weight loss, just the continued refusal to eat. Further interview with staff R revealed he/she was not aware of the resident had developed two stage 2 pressure ulcers in the facility. Physician R revealed his/her expectations of the facility was for the staff to notify him/her of the resident's significant weight loss and development of pressure ulcers and

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initiate treatment per the standing orders and prescribed treatment plans developed by the facility.

Review of the facility policy for Wound Care, last revised 3/12, revealed "Management of wounds will be determined by the following priorities: Stage II Partial Thickness Wound: Goal: To maintain a moist wound environment, manage excess exudates. Remove or minimize cause. 1. Continue Stage I interventions 2. Implement Dietary Stage II Standing Orders for Wound Care 3. Place on a specialty mattress if resident is nutritionally compromised and/or wound is not progressing 4. Dress a moist wound with a Poly Mem dressing and a dry wound with Derma Gram pending consultation with Physical Therapy for wound care orders and update the care plan as needed".

The facility failed to identify the resident had increased risk for the development of avoidable pressure ulcers by failing to address the poor nutritional intake of the resident revealed by the significant weight loss and provide preventative measures to prevent the development of two stage 2 avoidable pressure ulcers.

- Review of resident #28's signed physician orders dated 8/23/13 revealed a diagnosis of malnutrition (poor nutrition).

Review of the resident's admission MDS (minimum data set) dated 7/3/13 revealed a BIMS (brief interview for mental status) score of 6, indicating severe cognitive impairment. The resident required extensive assistance of one

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staff for bed mobility, eating, and personal hygiene, and extensive assistance of two staff for transfers and toileting. The MDS revealed the facility used a formal assessment tool to determine the resident's pressure ulcer risk. The resident was at risk of developing a pressure ulcer, but did not have any. The interventions the facility had in place to prevent pressure ulcers included a pressure relieving device for the chair and the bed, nutrition or hydration interventions, and applications of medications/ointments.

Review of the ADL (activities of daily living) Functional/Rehabilitation Potential CAA (care area assessment) dated 7/3/13 revealed the following analysis of findings: "[Gender] was recently in acute care for bilateral pneumonia [inflammation of the lungs], exacerbation of COPD [a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing], dehydration and malnutrition, anemia [a condition without enough healthy red blood cells to carry adequate oxygen to body tissues], and generalized deconditioning [a decrease in functioning of the heart muscle after a prolonged time of inactivity]... nutritional status is extremely poor and [gender] is weak... PT [physical therapy] is working with [gender] now 3 x [times] week and has shown a severe deficit in [gender] bilateral lower extremities. [Gender] does have difficulty with transfers and ambulation. [Gender] has to be fed by staff, otherwise, will not eat."

Review of the Nutrition CAA dated 7/3/13 revealed the following analysis of findings: "[Resident] was admitted to the LTCU [long term care unit] from acute care with generalized deconditioning, dehydration and malnutrition...

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has had a stroke... requires staff to feed [gender] or [gender] will not eat... has been put on Megace in addition to Remeron [both medications that can be used to stimulate the appetite] due to [gender] extremely poor nutritional status... is on a High Protein Regular diet with mighty shakes [a nutritional supplement] BT [between] meals and a 24 gm [gram] protein shake daily."

Review of the Pressure Ulcer CAA dated 7/3/13 revealed the following analysis of findings: "[Resident] is at high risk for pressure ulcer... scored 11 on the Norton scale [scoring system to predict pressure sore risk]... does require staff assistance for change of position... wears a brief for occasional urinary and stool incontinence."

Review of the resident's care plan for pressure ulcers, last revised 7/9/13, revealed interventions directing staff to conduct a systematic skin inspection by a licensed nurse weekly, report skin abnormalities to the physician, CNA (certified nurse aide) to conduct weekly systematic skin inspection with the resident's bath, paying particular attention to the resident's bony prominences and report any abnormalities to the charge nurse, provide a high protein regular diet with mighty shakes between meals, provide a 24 gram protein shake daily, feed the resident, use absorbent, skin-friendly incontinence briefs to maintain personal hygiene and dignity, use moisture barrier to perianal area after each incontinent episode, and use a pressure relief cushion when in the wheelchair or recliner chair, and heel protectors while in bed and float heels (keep the resident's heels off of the surfaces) when in the wheelchair. The care plan lacked that the resident had a pressure ulcer at any time or any treatments that had been used during the

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time the pressure ulcer was open.

Review of the resident's laboratory (lab) section of the chart revealed a low albumin (protein) level of 3.3 g/dl (grams per decaliter) (normal range for an adult female 3.9-5.2 g/dl) on 6/18/13 and no further lab had been drawn.

Review of the Physician Progress Notes dated 6/28/13 revealed "Skin: SCRAPES AND SCABS ON RIGHT KNEE." No further skin issues had been identified.

Review of a Medication Sheet in the nurse treatment book dated July 2013 revealed an entry to monitor the pressure ulcer between buttocks on right side, but had not been signed off during the month of July.

Review of a Nutritional Assessment dated 7/17/13 revealed the resident was new to long term care. By mouth intake was 60% of meal which was fair. Skin was intact. Labs show albumin was low.

Review of the Weekly Skin Sheet dated 7/31/13 revealed the resident had a stage II pressure ulcer (a shallow open ulcer with partial thickness loss of the dermis layer of the skin) between the buttocks on the right side that measured 6 cm (centimeters) x 2 cm without drainage and the form identified it developed in house.

Review of a CNA weekly skin assessment dated 8/6/13 revealed the resident had a sore on his/her buttocks and sores on his/her right toes.

Review of the Skin/Wound Care Charting dated 8/18/13 at 7:15 a.m. revealed, "Area deep pink. 0

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open noted."

Review of a Medication Sheet in the nurse treatment record book dated August 2013 revealed a sheet with an entry to monitor the resident's pressure ulcer to the buttocks. The pressure ulcer entry had been marked as closed on 8/25/13 and had not been initialed 6 times from 8/1/13 - 8/25/13.

Observation of direct care staff C on 9/4/13 at 10:49 a.m. revealed he/she took the resident to the bathroom, with the assistance of one other staff member and a gait belt. Staff assisted the resident to stand with the gait belt, cleaned the resident's peri-area after toileting, pulled the resident's pants up, and transferred the resident to the wheelchair with a chair pad approximately 2" thick in place. The resident's coccyx and buttock area was pink and without open areas.

Observation on 9/4/13 at 11:01 a.m. revealed direct care staff C and licensed nursing staff D assisted the resident from the wheelchair using a gait belt to stand and then used a pivot transfer to get the resident into his/her recliner and placed a chair alarm under the resident. The resident's wheelchair had a chair pad, but there was not any kind of chair cushion used in the resident's recliner. Staff clipped the resident's call light to his/her chair and put the button in his/her lap.

Observation on 9/4/13 at 12:17 p.m. revealed the resident sat in his/her recliner with the foot rest up, and direct care staff E sat on the arm of the resident's recliner and assisted him/her with the meal. The resident ate 30% of the regular diet of meatloaf, seasoned potatoes, green beans, and cake and drank a small glass of grape juice

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(approximately 120 (ml) milliliters). The recliner did not have a chair cushion in place.

Observation on 9/5/13 at 9:16 a.m. revealed the resident sat in his/her recliner with the foot rest up without a chair cushion in place.

Interview with direct care staff C on 9/4/13 at 10:49 a.m., staff reported the resident required total assistance of two people for daily cares.

Interview with direct care staff C on 9/4/13 at 2:03 p.m. confirmed the resident did not have a chair cushion in the recliner.

Interview with direct care staff C on 9/5/13 at 11:12 a.m. revealed the resident had previous skin breakdown from being bony on his/her coccyx, but did not know if the nurses had considered it a pressure ulcer. Staff C reported when the resident had the open area, the CNAs had a sealant cream they put on it, and the nurses had a patch on the area for a while, but did not know if staff had done any other interventions they had done differently once the area opened. Staff C reported he/she repositioned the resident every two hours.

Interview with direct care staff G on 9/5/13 at 2:39 p.m. revealed the resident previously had a place on his/her bottom that had a dressing on it and staff had put a sealant on it. Staff G revealed the area on the coccyx had been open, but he/she never saw it when the bandage was off of it. Staff G confirmed the resident did not have any open areas currently.

Interview with licensed nursing staff I on 9/5/13 at 12:50 p.m. revealed if a resident had a pressure

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ulcer, he/she expected the CNAs to offload the area. Staff I confirmed he/she would expect a pressure ulcer to be on the care plan.

Interview with licensed nursing staff H on 9/6/13 at 9:42 a.m. revealed pressure ulcers were measured weekly. Staff H reported when a pressure ulcer developed, the nurse who identified the wound initiated the wound protocol, then decided what kind of dressing the staff felt the wound needed, then notified the physician with recommendations based on the nurse's assessment and got orders for the care of the wound. Staff H reported for a stage I, staff usually did not use dressings. Staff H reported that the resident's pressure ulcer was a stage I when he/she saw it, so staff did not use a dressing at that time.

Interview with administrative nursing staff A on 9/6/13 at 10:38 a.m. revealed when a pressure ulcer developed, he/she expected the staff to follow the policy and procedures for pressure ulcers, including notifying the physician. Staff A confirmed he/she would expect a pressure ulcer to be on the care plan.

Review of the facility policy for Wound Care, last revised 3/12, revealed "... Stage I Superficial Wound: ... Keep pressure off area, do not use donut devices, off load heels as needed ... Stage II Partial Thickness Wound: Goal: To maintain a moist wound environment, manage excess exudates. Remove or minimize cause. 1. Continue Stage I interventions."

The facility failed to implement planned interventions for a chair cushion in the recliner to prevent the development of a pressure ulcer for a

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| F 314 | Continued From page 52<br>resident the facility identified as at risk for pressure ulcers. | F 314 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility census totaled 33 with 18 residents included in the sample. Based on observation, interview and record review the facility failed to thoroughly investigate falls and develop interventions to reduce the resident's risk for falls for 3 of 3 residents sampled. (#11,#28,#17) The facility also failed to safely store harmful chemicals out of the reach of the residents which had the potential to affect 7 cognitively impaired, independently mobile residents and the failed to secure and monitor a crock pot to prevent the risk for burns, for the independently mobile and residents in the facility.<br><br>Findings included:<br><br>- Review of resident #11's physician's orders sheet signed and dated on 7/24/13 revealed the resident had a diagnosis of senile dementia (short and long term memory impairment).<br><br>Review of the annual MDS (minimum data set) | F 323 | | |

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dated 2/13/13 revealed the resident had short and long term memory loss with moderately impaired decision making ability The resident was dependent on staff for bed mobility, transfers, locomotion, dressing, and toilet use. The resident required extensive assist of one staff for personal hygiene, eating and bathing. The resident had one non-injury fall since the last assessment.

Review of the cognitive loss/dementia CAA (care area assessment) dated 2/14/13 revealed the resident was confused due to the diagnosis of senile dementia. The resident had short and long term memory impairment most of the time and was able to recognize familiar faces of staff that care for him/her on a daily basis, and his/her family members.

Review of the ADL (activities of daily living) CAA dated 2/14/13 revealed the resident was alert, confused, and required staff assistance for all his/her ADL's, from total assist with full lift for transfers to one person assist as needed with eating. The resident had senile dementia and received hospice services.

Review of the Fall CAA dated 2/14/13 revealed the resident was at risk falls for and had one fall this past quarter, prior to that fall it had been almost a year since the resident's last fall. Review of the 3/25/13 incident revealed the resident's roommate observed him/her attempting to get out of bed on his/her own and slid to the floor without injury.

Review of the Quarterly assessment dated 8/20/13 revealed the resident had short and long term memory impairment with moderately impaired decision making abilities. The resident

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required extensive assist of one staff member for eating, personal hygiene and bathing. The resident was dependent on staff for all other aspects of his/her ADL's.

Review of the care plan dated 5/20/13 revealed the resident was at risk for falls. The care plan directed the staff to assess the resident for the cause of falls, complete post fall monitoring per the LTCU (long term care unit) protocol, complete a fall risk assessment quarterly and PRN (as needed).

Review of the care plan updated on 3/25/13 fall mat on floor next to bed.

Review of the care plan update on 5/10/13 revealed resume non-skid adhesive to the rock n go chair (specialized wheel chair) while the resident was up.

Review of the care plan updated on 5/20/13 revealed the resident received a new rock n go chair.

Review of the care plan updated on 6/5/13 revealed the left side of the resident's bed was turned against the wall continue to place fall mat to the other side of the bed.

Review of the Physical Assessment Form Following a Fall, revealed the resident fell at 12:30 p.m. on 3/25/13, the resident had a history of falls and the fall was unwitnessed. The assessment had the following notation: "found on floor between bed/wall laying prone (flat). C/O (complained of) Lt (left) hip/knee pain, no deformities. X-ray taken - bed rest per nursing measure till x-ray results return. Family and

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physician notified". The new intervention for the fall was "bed rest per nursing measure R/T (related to) pain in Lt (left) hip post hip Fx (fracture) with surgical repair".
Review of the Fall Risk Assessment form revealed the facility failed to complete a fall risk assessment after the fall on 3/25/13.
Review of the Fall Risk Assessment dated 5/20/13 revealed a score of 19 (high risk for falls).
Review of the Physical Assessment form following a Fall revealed the resident fell at 6:05 a.m. on 6/5/13, the resident had a history of falls, and the fall was unwitnessed. The assessment had the following notation: "heard resident say "help me, I can't get up" upon entering the room noted resident's upper torso on bed c (with) Rt (right) arm against the 1/4 (quarter) bed rail. Both knees on the floor, bed in low position. Lowered to the floor with gait belt x (with) 3 assist. Full lift used to return {gender} to bed. The new intervention for the fall was "moved bed against the wall et (and) mattress on the floor of the other side". The physician and family was notified of the fall.
Review of the resident record revealed the facility failed to complete a fall risk assessment after the fall dated 6/5/13.
Review of the interdisciplinary progress notes revealed the following entries:
Review of the Nurses Notes dated 6/5/13 at 5:50 p.m. revealed "at 6:05 a.m. the resident was found with his/her knees on the floor and his/her upper body still on the bed. Three staff members assisted the resident to the floor using a gait belt, then sling placed and resident returned to the bed. Assessment done. Resident out to breakfast and lunch. (family member) notified and they said they would call in the morning to check on {gender}. Dr. notified via fax. Post fall VS (vital

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signs) will be done for 3 days q (every) shift. "
Review of the Nurses Notes dated 6/6/13 at 4:40 p.m. revealed " Doctor advised of holding BP (blood pressure) medications for 3 days for low BP . Advised to continue to hold et (and) report. At breakfast, resident color was ashen and was very sleepy. HR (heart rate) slightly irregular. BP high at lunch and more awake. At 3:00 p.m. resident awakened easily and drank supplement. Bruise noted to FA (fore arm) about 6 cm (centimeter) in size. C/O (complaints of) tenderness when touched. "
Review of the Nurses Notes dated 6/6/13 at 3:20 p.m. revealed " Res (resident) has multiple bruises from fall, c/o tenderness when touched to look @(at). Res moves extremities slowly. Skin wm(warm)/dry -Denies pain @ this time. "
Review of the Nurses Notes dated 6/7/13 at 9:45 a.m. revealed " Res c/o everything hurting, had her scheduled Tylenol (over the counter pain medication). B/P (blood pressure) still been low earlier this AM- B/P med held as was told, order gotten by [staff initials and credentials]. Resident does open eyes to verbal stimuli, smiles and talks to staff. Multiple bruises cont (continue) to be present. Resting in bed @ this time c (with) call light in reach. "
Review of the Nurses Notes dated 6/7/13 at 8:00 p.m. revealed " Resident up to DR (dining room) for supper this evening. C/O pain in rt (right) rib area when staff repositioned {gender}. No bruising noted. "
Review of the Nurses Notes dated 6/8/13 at 1:00 p.m.- revealed " Resident c/o pain all over this morning. Does have a small light bruise to R (right) upper quadrant (upper area of the abdomen) about 2 cm (centimeter) circle. The bruise to his/her RFA (right fore arm) remains reddish-purple outside the usual skin

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discoloration of dark brownish/black. The entire area is about 6 cm long. Resident ate small amounts for breakfast. BP has started coming back up. "
Review of the Nurses Notes dated 6/8/13 at 9:00 p.m.- revealed "Resident in bed, c/o R (right) side pain- to rib area when palpated. CNA (certified nursing assistant) reports resident yells and c/o pain when transferred with lift et repositioned in bed. No bruising noted ... Physician notified @ this time re (regarding): resident c/o pain with movement 2 [secondary] to fall 6/5/13. Order received to obtain x-ray R (right) ribs on 6/9/13. "
Review of the Nurses Notes dated 6/9/13 at 5:00 p.m. revealed " The resident was taken to Radiology by gurney for a CXR (chest x-ray) @ 0820 c 2 aides (nursing assistants) ... No c/o pain. Scheduled Tylenol given. "
Review of the Radiology report dated 6/9/13 revealed the following:
Reason for exam: fall on 6/5/13 , increased pain
Findings included:
Impression: Multiple rib fractures as described above.
The report was stamped received and signed by the resident's physician on 6/10/13.
Review of the Nursing Home Note dated 6/26/13 revealed the resident was under the care of hospice for progressive dementia. The resident had a fall a couple of weeks ago and had increase pain. Multiple rib fractures on the right side were identified. The resident was placed on a Fentanyl patch (prescribed pain medication) that helped control the resident's pain.
On 9/4/13 at 11:00 a.m. observation revealed the resident lay mid-line on an an air mattress to his/her bed with quarter side rails up bilaterally. The left side of the resident's bed was not against the wall. The bed was angled away from the wall

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approximately 2 1/2 feet from the edge of the bed to the wall. The resident had a mattress to the floor on the right side of his/her bed, but not on the left side.

On 9/5/13 at 2:09 p.m. observation revealed the resident lay in bed mid-line with his/her eyes closed The left side of the resident's bed was not against the wall. The bed was angled away from the wall approximately 2 1/2 feet from the edge of the bed to the wall. The resident had a mattress to the floor on the right side of his/her bed.

On 9/6/13 at 10:19 a.m. the resident was observed in bed with his/her eyes closed. The left side of the resident's bed was not against the wall. The bed was angled away from the wall approximately 2 1/2 feet from the edge of the bed to the wall. The resident had a mattress to the floor on the right side of his/her bed, but not on the left side.

On 9/6/13 at 10:15 a.m. an interview direct care staff C revealed he/she was unable to recall the fall on 6/5/13. Staff C revealed the resident was to have the left side of his/her bed placed against the wall and a mattress to the floor on the right side of the resident's bed. Direct care staff C revealed the resident had a mattress to the floor on the right side of the bed because he/she had fallen off the right side of the bed onto the floor before. Staff C confirmed the resident's bed was not positioned against the wall.

Attempts to contact the licensed nurse on duty at the time of the fall were unsuccessful on 9/6/13 and 9/11/13.

On 9/5/13 at 3:41 p.m. an interview with

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Administrative nurse B and management staff X revealed the facility was aware the resident fell out of the bed on 6/5/13 but was unaware that the resident had sustained four fractured ribs diagnosed on 6/10/13 as a result of the fall. Staff X revealed the facility had no further investigation of the fall. Staff X revealed the "incident nurses notes" at the time of the fall revealed the resident had no complaints of pain and no noted injuries so he/she did not do any follow up investigation of the incident. Staff B revealed all x-ray reports and lab results were to be placed on his/her desk for review and signature. However, he/she had never seen the radiology report for the resident that diagnosed the fractured ribs. Staff B and staff x revealed the first knowledge of the resident's fractured ribs was on 9/5/13 when further information for the fall on 6/5/13 was requested during the annual survey.

On 9/6/13 at 11:12 a.m. an interview with Administrative nurse A revealed the facility charge nurses were responsible for filling out the fall report after each fall, updating the fall assessment, and placing a new intervention to reduce the resident risk for falls on the care plan after each fall. Staff A confirmed the he/she had no knowledge of the resident's fractured ribs. Staff A confirmed the resident's bed was not placed against the wall as directed by the care plan to reduce the resident risk for falls.

The facility failed to thoroughly investigate and implement interventions to prevent the resident from falling; as a result the resident sustained significant injuries including fractures of four ribs.

- On 9/5/13 at 12:45 p.m. observation revealed a

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crock pot filled with wet wash cloths sat on a cabinet in the dining room. The crock pot was turned to the off setting. The crock pot locking devices were not secured. The outside of the crock pot was warm to the touch and the inside temperature of the crock pot was 125 degrees Fahrenheit. The observation of the crock pot at this time revealed no residents in the dining room and a facility housekeeper in the dining room. The lid was on but not locked.

On 9/5/13 at 12:25 p.m. interview with Licensed nurse D revealed the facility did not have a standard protocol for monitoring the crock pot to ensure the lid was locked and the facility had not tested the crock pot temperature internally or externally. Staff D revealed no specific staff member was responsible to monitor the temperature or ensure the crock pot was set at the warm setting. Staff D revealed whoever noticed the crock pot needed to be turned on would switch the crock pot to the warm setting and usually the last staff member out of the dining room turned the crock pot off. Licensed nurse D confirmed the crock pot was turned to the proper setting and the lid locks were not in place.

On 9/6/13 at 2:22 p.m. interview with Administrative staff A revealed the facility had not developed a policy regarding the use of the crock pot to keep wash clothes to clean the resident's hands and faces after a meal. Staff A confirmed the facility failed to temp the crock pot and ensure proper supervision of the crock pot while in use.

The facility failed to provide a policy regarding the use of the crock pot when requested on 9/5/13.

The facility failed to ensure the crock pot was set

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to a safe temperature to prevent potential injuries to the residents who required a wash cloth for staff to wash their hands and face.

- Review of resident #17's signed physician orders dated 8/1/13 revealed diagnoses of: vertigo (dizziness), and macular degeneration (progressive deterioration of the retina). Review of resident #17's admission MDS (minimum data set) dated 2/1/13 revealed a BIMS (brief interview for mental status) with a score of 10 (moderately impaired). The MDS revealed that the resident was independent with bed mobility and required limited assist of 1 person to transfer, walk in room, dress and toilet. The MDS recorded the resident had 2 or more non-injury and 1 injury fall since admission.

Review of the quarterly MDS dated 7/31/13 revealed BIMS of 8 (moderate cognitive impairment). The resident was independent and required no assistance with bed mobility, transfers or walking, but required limited assist of 1 for dressing and only supervision and no assist for toileting. The MDS revealed that the resident had non-injury falls in the last month and falls in the last 2-6 months.

Review of the cognitive loss/dementia CAA (care area assessment) dated 2/5/13 revealed the resident admitted on 1/18/13 from acute care. Prior to hospitalization the resident lived with his/her adult child. The resident started becoming agitated and more confused towards the adult child. The resident had hypoxia (inadequate supply of oxygen). The resident had a history of syncope spells (fainting or loss of consciousness caused by temporary lack of oxygen) and

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required oxygen full time.
Review of the Activities of Daily Living CAA dated 2/5/13 revealed a significant decline in functional status following the recent hospitalization. The resident had a decline with strength, as well as mentation. The residents' endurance was fair. The resident transferred with a sit to stand lift and was independent with standing balance. The resident ambulated with use of a front wheeled walker and 1 person assist for safety.
Review of the Fall CAA dated 2/5/13 revealed the resident had a history of falls at home prior to facility admission, due to use of Flexeril (a muscle relaxer) for cervical neck arthritis and severe degenerative arthritis. The resident fell 3 times since admit with minor injury. The resident was alert but had periods of syncope and the oxygen level dropped quickly, blood pressure drops and resident got dizzy, per discharge summary dated 1/18/13, The resident could tell you how to use the call light but the resident did not do it. The resident also bent over and picked things up and went to the bath room alone. Remind the resident not to ambulate in stocking feet.

Review of the care plan with a date of 2/5/13 revealed the following problems: Falls, complete quarterly fall risk assessment and PRN (as needed). The resident had confusion with agitation. Staff to complete post fall monitoring per LTC (long term care) facility protocol. Assume standing position slowly, assure the resident has pressure alarm on in the bed and is turned on and working. Ensure the resident is wearing oxygen at 2 liters/minute; obtain oxygen saturation and vital signs. Resident needed cueing. On 5/24/13, remind not to ambulate in stocking feet. On 8/18/13, remind resident the importance of using the call light. On 8/21/13,

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remind to call for assist. On 8/21/13, make sure the alarms are on and in place. Resident's family has purchased a black and yellow gait belt the "tool belt" resident accepts easier. The resident continued to ambulate to and from meals and activities with walker and 1 assist. The care plan indicated the resident refused assistance while walking.
Review of the Fall Physical Assessment form dated 8/18/13 at 4:00 p.m., revealed the resident returned to the facility from an outing with the family. The family lowered the resident to the floor after losing balance. The resident had abrasions to the right palm and right elbow. The resident also suffered a skin tear to the right forearm measuring 0.5 x 0.5 cm (centimeters) and outer elbow 7 x 5 cm and 2 x 2 cm to inner elbow left upper right elbow 3 x 3 cm. The resident reported trying to open his/her door and lost balance. Resident was to use the call light for assist for ambulation and transfers in his/her room with gait belt and walker. The resident required 1 assist for the next 24 hours to assess for weakness.

Review of the Fall Physical Assessment form dated 8/8/13 at 3:45 a.m., revealed the resident's feet got tangled in the covers. No call light sounded, and the resident was sitting on the floor next to the bed alarm that did not sound. The resident denied pain. Assist of 2 staff with a gait belt was required to get the resident up. The resident walked with a front wheeled walker to the restroom; no injury found. Initiation of special monitoring sheets with documentation every 30 minutes on the resident and visual check made and initialed for the checks.

Review of the Fall Physical Assessment form dated 8/21/13 at 4:00 p.m., revealed an

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un-witnessed fall while the resident was going back to bed after going to the bathroom. The resident slid off the side of the bed to the floor and onto his/her knees. The resident had an abrasion to the knees. The resident had impaired balance. Intervention; nonskid socks, alarms, call light and reorientation to call for help.

Review of the Fall Physical Assessment form dated 8/26/13 at 9:30 p.m., revealed the resident was on the toilet having a bowel movement and bearing down. The resident got light headed and staff lowered him/her to the floor. The resident had abrasions to the right hand knuckle and left clavicle. The resident had impaired balance. Interventions; included to provide assistance of 2 staff.

Review of the direct care pocket sheets and the care plan revealed no mention of the 30 minute checks. There was no documentation of the staff completing the 30 minute checks as planned.

On 9/4/13 at 11:06 a.m., the resident was in the recliner sitting straight up with feet on the floor. The resident had the call light with in reach on the arm of the chair and an alarm attached further on the side of the chair.

On 9/4/13 at 11:30 a.m., the resident ambulated to the dining room with walker, gait belt, with the family member walking along and not holding the gait belt. The resident had shoes on.

On 9/5/13 at 2:30 p.m., observation revealed the resident was up and out of the recliner on the way to the bathroom, independently and the gait was unsteady, oxygen tubing trailing behind him/her, and the alarm sounded. Direct care staff J went

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into the resident's room and assisted him/her into the bathroom, and stayed with the resident.

On 9/4/13 at 2:10 p.m., direct care staff J and K reported that the resident required assistance of 1 person for transfers and ambulating. The resident had several falls and received the skin tears. Now resident needed more assistance than before. The resident could use the call light, and could get up and walk so when the staff came in to the room staff took him/her to the bathroom. The resident turned off the alarm by him/herself.

On 9/5/13 at 2:30 p.m. direct care staff J reported that the direct care staff book had the (care plan) pocket sheet for all the staff and new employees and agency. This resident plan on the pocket sheet indicated that he/she was using the alarm and used the walker sometimes he/she was more confused than others. The resident was a fall risk, and had pressure alarm on the bed. The staff must check on him/her at night. The resident must have stand by assistance when ambulating. Staff does not check this resident on a regular basis. The area for the 30 minute checks was not marked. Direct care staff J reported that he/she was not sure why the staff were not doing checks on this resident.

On 9/5/13 at 1:04 p.m., licensed nursing staff I revealed that the pressure alarm, tabs alarm, were on, but the resident was non-compliant with them if he/she was feeling good. The resident continued to get up and ambulate on his/her own. The resident was to be on the pressure alarm and every 30 minute checks by staff. The staff was to be documenting on the sheet in the direct care staff book. The checks were not done.

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On 9/5/13 at 4:53 p.m., licensed nursing staff M reported on several occasions, the resident had removed the alarm in front of the staff. The adult child stated the resident could turn off the alarms. The resident had a pressure alarm and was checked on more often than the usual 2 hours in the night. The resident just got up and went to the bathroom as he/she had to go to right away to remain continent of urine, and would not wait for the staff to answer the light if he/she used it.

On 9/5/13 at 4:55 p.m., administrative nursing staff A revealed that 30 minute checks were not being done, but the resident had an alarm on. Administrative nursing staff reported he/she was unsure of why he/she was not on the 30 minute checks. The 30 minute checks were planned for on the Fall Physical Assessment form, but did not get put onto the care plan or the pocket sheet.

Review of the Fall Assessment Policy dated on 6/20/00 and revised on 3/12/12 revealed:

PURPOSE: To ensure the resident's health and wellbeing following a fall.

PROCEDURES: Initial fall risk on admission. Monitoring Blood Pressure, Temperature, Pulse, Respiration, Oxygen saturation. If the resident has hit his/her head, check the level of consciousness, pupils, strength, and coordination in addition to the above items.

The facility failed to develop and implement effective interventions to prevent falls for this cognitively impaired resident with a history of falls.

- Review of resident #28's signed physician

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orders dated 8/23/13 revealed the following diagnoses: hypopotassemia (low potassium level in the blood), senile dementia (general loss of cognitive abilities), affective personality disorder (chronic mood disturbances), paralysis agitans (impairment in motor function due to loss of function of certain brain cells), atrial fibrillation (rapid irregular heartbeat), cerebral ischemia (insufficient blood flow to the brain), urinary incontinence (involuntary passage of urine), and trigeminal neuralgia (nerve disorder that causes pain spasms in the face).

Review of the resident's admission MDS (minimum data set) dated 7/3/13 revealed a BIMS (brief interview for mental status) score of 6, indicating severe cognitive impairment. The resident had adequate hearing and vision, wore glasses, spoke clearly, understood others, and was understood by others. The resident required extensive assistance of one staff for bed mobility, eating, and personal hygiene, and extensive assistance of two staff for transfers and toileting. The resident had received 130 minutes over 6 days of physical therapy. The resident fell in the month prior to admission, in the 2-6 months prior to admission, and had a fracture related to a fall in the 6 months prior to admission. The resident had not fallen since admission.

Review of the ADL (activities of daily living) Functional/Rehabilitation Potential CAA (care area assessment) dated 7/3/13 revealed the following analysis of findings: "[Resident] has a history of falls. [Gender] was recently in acute care for bilateral pneumonia [inflammation of the lungs], exacerbation of COPD [a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in

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breathing], dehydration and malnutrition, anemia [a condition without enough healthy red blood cells to carry adequate oxygen to body tissues], and generalized deconditioning [a decrease in functioning of the heart muscle after a prolonged time of inactivity]... was very weak upon admission to the hospital, after being hydrated, [gender] showed improvement. nutritional status is extremely poor and [gender] is weak... did have a fall in the hospital and sustained a nondisplaced fracture of [gender] coccyx. PT [physical therapy] is working with [gender] now 3 x [times] week and has shown a severe deficit in [gender] bilateral lower extremities. [Gender] does have difficulty with transfers and ambulation. [Gender] has to be fed by staff, otherwise, will not eat."

Review of the Falls CAA (care area assessment) dated 7/3/13 revealed the following analysis of findings: "[Resident] is at high risk for falls and has had recent falls prior to [gender] LTC [long term care] admission... fell in acute care and sustained a Fx (fractured) coccyx... nutritional status is very poor and [gender] has generalized deconditioning. PT assess [assessment] on 6-25-13 identified [gender] with poor balance, uneven stuttering type steps with ambulation, and a severe deficit with strength."

Review of the resident's care plan for ADL Functional/Rehabilitation Potential, last revised 8/14/13, revealed interventions directing staff to use a gait belt and two staff to assist the resident with the toilet, padded back rest with lumbar support to promote upright position, gel cushion to prevent pressure ulcer, foot rests with calf plates to promote lower extremity positioning, ambulate with FWW (front wheeled walker) and two assist and distance as tolerated, and keep

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heel rests on the foot plates off of the wheelchair to prevent pressure ulcers.

Review of the resident's care plan for Falls, last revised 7/8/13, revealed interventions directing staff to assure the resident wore his/her glasses, provide adequate footwear, complete a fall risk assessment after each fall per LTC protocol, encourage the resident to assume a standing position slowly and frequently remind him/her to lift up his/her head and stand tall and straight, give verbal reminders not to ambulate/transfer without assistance, ensure the call light is within reach, provide toileting assistance every 2 hours on the even hours while awake, and provide a FWW when the resident ambulated using a gait belt and two person assist. No interventions had been added.

Observation of the North hall care plan book on a "15/30 minute checks/Tabs Monitors/ Code Alerts" revealed the list lacked the resident's name.

Review of a fall risk assessment form revealed the assessment had been completed on 6/20/13, 7/3/13, and 8/10/13 with scores of 11, 19, and 19, indicating increased risk for falls. For the 8/10/13 assessment, staff did not complete the section for medications and systolic blood pressure. The form also had preventative measures listed that had been implemented on 6/20/13 for referral to therapy and personal alarm and on 7/3/13 revealed interventions directing staff to use a personal alarm, complete a laboratory review, side rail screen, and pain assessment, use a toileting program, and update the care plan. These interventions were not added to the care plan.

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Review of the Physical Assessment Form Following a Fall dated 8/10/13 revealed the resident had a history of falls, staff witnessed the fall, and the resident had been lowered to the floor with assistance. Staff completed vital signs, a skin assessment, a neurological assessment, an assessment of the environment, and completed range of motion (ROM). The resident sustained no injuries The resident had confusion and impaired balance. The form indicated staff notified the family, but not the physician. The form also included a comment written to "Consider using chair alarm while pt [patient] up in the chair," even though that had been listed as an intervention to prevent falls with the fall risk assessment on 6/20/13 and 7/3/13.

Observation on 9/4/13 at 11:01 a.m. revealed direct care staff C and licensed nursing staff D assisted the resident from the wheelchair using a gait belt to stand and then pivot transfer to his/her recliner and placed a chair alarm under the resident. Staff clipped the resident's call light to his/her chair and put the button in his/her lap.

Observation on 9/5/13 at 9:16 a.m. revealed the resident sat in his/her recliner with the foot rest up and a chair pad alarm in place and on.

Observation on 9/4/13 at 1:59 p.m. revealed direct care staff C and F assisted the resident to walk to the bathroom with a FWW and a gait belt. The resident urinated in the toilet and then requested to lay down in bed. Staff F then hooked the resident's call light to the bed rail within reach and hooked up the sensor alarm to the bed.

Interview with direct care staff C on 9/5/13 at

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11:12 a.m. revealed the resident had not had any falls recently, at least not on day shift. Staff C reported the resident had pressure sensor pads on the chair and bed and used the alarms all the time to keep the resident from falling out of bed and the chair. Staff C also reported the resident had foot pedals on the wheelchair to keep the resident from getting his/her foot caught on the ground and falling out of the wheelchair.

Interview with direct care staff G on 9/5/13 at 2:39 p.m. revealed he/she did not know of any falls the resident had, and that he/she would know from the communication book that all staff were supposed to read each morning. Staff G reported that he/she also knew if a resident were a fall risk from the communication book. Staff G reported usually if a resident had a pressure alarm pad, they were also on visual checks. Staff G reported the resident should have a pressure alarm on when in the wheelchair, recliner, and the bed.

During an interview on 9/5/13 at 3:35 p.m., direct care staff T reported the resident, "might have a pressure pad."

Interview with licensed nursing staff I on 9/5/13 at 12:50 p.m. revealed if a resident fell, the nurse assessed for injuries, performed ROM, assessed vitals, decided whether to assist up to sitting, then standing, determined when the resident went to the bathroom last, assessed the surroundings for environmental factors, called the doctor and family, and filled out all of the pages of paperwork. Staff I reported staff were expected to update the care plan after every fall. Staff I reported that for residents at risk for falls, staff commonly used interventions directing staff to keep the call light within reach, put a mattress on

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the floor, and keep a tabs monitor in place. Staff I reported residents were determined to be a fall risk based on an assessment with questions addressing how steady the resident stood and walked, if the resident had fallen before, specific kinds of medications the resident took, and hydration. Staff I reported he/she did not know if staff had used a pressure sensor alarm before the resident's fall on 8/10/13 or if it had been added after.

Interview with licensed nursing staff H on 9/6/13 at 9:42 a.m. revealed a fall investigation should include an initial quick assessment, for bleeding, broken bones, vitals, pain, mobility, and neurological changes, an assessment of the environment, when the resident had gone to the bathroom last, if the resident had been wearing shoes, if a chair pad alarm had been in place, and any hazards that were in the way. Staff H reported the nurse should notify the staff that cared directly for the resident, administrative nursing staff A and B, the administrator, the therapy department, the resident's family, and the doctor. Staff H reported the care plan should be updated with a new intervention for each fall. Staff H reported he/she did not know of any falls the resident had. Staff H reported staff learned of falls from a recorded report for the next shift and a communication book for the CNAs and the nurses.

Interview with administrative nursing staff A on 9/6/13 at 10:38 a.m. revealed with falls he/she expected the care plan to be updated immediately, as it would need a new intervention based on the cause of the fall. Staff A reported he/she did not expect the staff to change the care plan if the interventions were appropriate and

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staff were not following it. Staff A reported he/she would expect the fall investigation form to be completed and a better picture painted as to what happened at the time of the fall.

Review of the facility policy for Fall Assessments, last revised 3/12/12, revealed, "Purpose: To ensure the residents health and well being following a fall..." The policy lacked direction for staff to evaluate the interventions that were in place at the time of the fall, adding interventions, or updating the care plan.

The facility failed to implement the planned intervention of a chair alarm to prevent a fall for resident #28, a resident with a history of injuries related to falls.

- On 9-3-13 at 2:20 p.m. observation revealed a large plastic dispensing container of Cavi wipe towelettes in the bathroom of one resident. The container carried the following warnings, "Keep out of reach of children" and "Caution do not use as a baby wipe." The labeling also warned not for use on skin, hazardous to humans and domestic animals, caution harmful if absorbed through the skin, causes moderate eye irritation, avoid contact with eyes, skin or clothing, wash hands before eating, drinking, chewing gum, using tobacco or using the toilet, and remove contaminated clothing and wash clothing before reuse. Direct care staff G confirmed their placement and removed them.

Observation on 9/3/13 at 2:33 p.m. revealed another container of cavi wipes in a resident bathroom. Direct care staff G confirmed their placement and removed them.

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Observation on 9/4/13 at 10:22 a.m. revealed 2 containers of cavi wipes hung in an isolation precautions kit from the door of a resident room and were not secured in any way.

Observation on 9/5/13 at 10:15 a.m. revealed chemicals in the following areas: one resident bathroom contained a spray container of Renuzit super odor neutralizer that hung on the grab bar, the east hall charting station on an open shelf had 2 containers of cavi wipes and 4 containers of Renuzit super odor eliminator, the north hall charting station had 5 containers of cavi wipes in an unlocked lower cabinet, the unlocked public women's bathroom in the south hall had an unsecured spray container of Renuzit super odor neutralizer, the open and unattended restorative office had a container of cavi wipes on the countertop and one in a portable cart, and the unlocked men's public bathroom had an unsecured container of cavi wipes. The Renuzit super odor neutralizer warning label read, "CAUTION - CONTAINS ETHANOL" Eye Irritant: if eye contact occurs, flush with water for 15 minutes. If irritation persists, seek medical attention." KEEP OUT OF REACH OF CHILDREN AND PETS." There were 2 large containers of CaviWipes Towelettes. The container carries a warning to Keep out of reach of children. Another caution noted not to use as a baby wipe. Not for use on skin. Precautionary statements included Hazardous to Humans and Domestic Animal. Caution Harmful if absorbed through the skin. Causes moderate eye irritation. Avoid contact with eyes, skin or clothing. Wash hands before eating, drinking, chewing gum, using tobacco or using the toilet. Remove contaminated clothing and wash clothing before reuse. Licensed nursing staff D confirmed the

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| F 323 | Continued From page 75<br>placement of the chemicals and began to remove them.<br><br>Interview on 9/3/13 at 2:33 p.m. with direct care staff G confirmed the cavi wipes should not be stored in a place accessible to residents and confirmed the wipes had a warning on the label.<br><br>Interview on 9/5/13 at 10:13 a.m. with licensed nursing staff D revealed he/she knew anything with a warning on it to "keep out of reach of children" should be locked up and inaccessible to the residents. Staff D stated, "Well, it looks like staff are just keeping those things where it is convenient for them to use, but that isn't safe for the residents."<br><br>Interview on 9/6/13 at 10:38 a.m. with administrative nursing staff A revealed he/she expected anything that had a "keep out of reach of children" warning or that could be hazardous to the residents to be locked up. Staff A reported that if a resident had their own personal cleaning items, the resident was responsible for ensuring it was secured, but all the chemicals used by the facility were the facility's responsibility to secure.<br><br>The facility failed to protect residents from hazards by failing to secure potentially hazardous chemicals which had the potential to affect 11 cognitively impaired, independently mobile residents. | F 323 | | |
| F 325 SS=G | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a resident - | F 325 | | |

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| F 325 | Continued From page 76<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 33 residents. The sampled included 18 residents, with 4 residents sampled for nutrition. Based on observation, interview and record review the facility failed to monitor and act upon nutritional interventions to prevent weight loss in 3 of 4 residents sampled.(#5, #11 and #30).<br><br>Findings included:<br><br>- Review of resident #5's signed physician orders dated 7/19/13 revealed the following diagnoses: depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), pain (an unpleasant feeling), hyponatremia (low sodium), malnutrition (condition that results from eating a diet in which certain nutrients are lacking or in the wrong proportions) of mild degree, and dementia (progressive mental disorder characterized by failing memory, confusion).<br><br>Review of the resident annual MDS (minimum data set) dated 11/6/12 revealed a BIMS (brief interview for mental status) score of 5 (severely cognitively impaired). The functional status revealed the resident required extensive | F 325 | | |

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assistance of one person for eating. The MDS recorded the resident did not have weight loss or gain. The resident weighed 173 pounds and had a loss of liquids /solids while eating and cough and choking while eating or taking medications. The resident received a mechanically altered diet.

Review of the quarterly MDS dated 7/13/13 the resident had moderately impaired cognition. The functional status revealed the resident was totally dependent on 1 staff for eating and had a loss of liquids/solids from mouth while eating. The resident's weight was 148 pounds. The assessment indicated the resident had no weight loss or gain and received a mechanically altered diet.

The Nutrition CAA (care area assessment) dated 11/6/12 did not trigger.

Review of the care plan with a date of 1/30/13 revealed a problem with nutritional status. The staff were to assist the resident with eating as allowed or as requested. Remind the resident to eat slowly and take small bites. Use a colored lip plate and other adaptive devices as needed. The resident had a history of choking. The resident was to receive nectar thick liquids at all times. The resident's family brought in foods and candy that the resident kept in the room. Staff were to ask the resident if he/she wanted some candy with cares. Elevate the head of the bed 30 degrees at all times. Follow the physician orders for the diet and allow the resident extra time to eat.

On the care plan revision dated 5/1/13 the resident had a 14.9% (percent) weight loss in 6 months. Begin Breeze (a dietary supplement) 2

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times daily. The staff were to assess the amount of supplement taken prior to documenting the percentage in the MAR (medication administration record). No other changes were made to the care plan regarding nutrition.

On 9/5/13 review of the direct care staff pocket sheet, indicated that the resident needed assistance with eating. Staff were to encourage the resident to do what he/she could for him/herself. The resident required thickened liquids and assistance for eating.

Review of the resident's weights revealed the following:

9/12 - 176 pounds
10/12 ---- no weight found for October
11/12 - 174 pounds
12/12 - 173 pounds
1/13 - 158 pounds an 16 pound weight loss in 3 months (11/12 to 1/13), (9.19%). Significant weight loss.
2/13 - 152 pounds an 6 pound weight loss in 1 month (1/13 to 2/13)
3/13 - 147 pounds a 24 pound weight loss in 5 months, ( 9/12 to 3/13), (16.4%)
4/13 - 148 pounds
5/30/13 - 147 pounds
7/24/13 - 149 pounds
8/29/13 - 144 pounds and continued weight loss 5 pounds in 1 month
The clinical record lacked documentation of physician notification, orders or interventions from the 1/13 (first significant weight loss) and 3/1/13 (2nd significant weight loss) until 5/12/13.

On 3/28/12 physician order for Arginaid 1 at breakfast and supper, for wound healing.

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On 5/12/13 physician order for Breeze, supplement 240 ml (milliliter) 2 times daily.
On 5/21/13 physician order for resident to have finger foods as snacks and at meals.

Review of the dietary progress note dated 2/4/13, revealed the resident received a regular diet with soft with finger foods and 1 ounce of extra protein per meal. The resident weighed 156 pounds. Labs showed a low albumin (protein level). The resident would benefit from verbal encouragement to eat protein rich foods and drink. PLAN: Recommend the staff to encourage the resident to eat protein rich foods and monitor.

Review of the dietary progress notes dated 5/8/13, revealed the resident's oral intake was fair at 50%. The resident would benefit from verbal encouragement to eat protein rich foods and drink. PLAN: encourage the resident to eat protein rich foods, drink fluids and monitor.

Review of the dietary progress notes dated 8/7/13 revealed the resident's oral intake was poor at 53%. The resident had weight gain of 5# in 3 months, not a significant figure. PLAN: Recommend staff encourage the resident to eat protein rich foods, drink fluids monitor and follow the resident.

On 9/6/13 review of the August 2013 MAR revealed there were no signatures to document that the resident received the Arginaid for evening dose on 11, 14, 15, 16, 17, 19, 20, 22, 23, 24, 25, and 26 or for the Breeze supplement on the evening shift on 9, 14, 15, 16, 19, and 20.

Review of the July 2013 MAR revealed the Arginaid not signed for on 24, 26, 28, 29, and

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Breeze supplement not signed for on 12, 24, 25, 26, 27, 28, and 30.

On 9/6/13 review of the meal intake sheets for June, July and August 2013 revealed that the resident ate an average of 50 % .

On 9/4/13 at 11:25 a.m., a staff member assisted the resident to eat. The resident received a regular mechanical soft diet of meatloaf, potatoes, green beans, Jell-O and thickened orange drink, soda and water in 240 ml glasses.

On 9/4/13 at 12:08 p.m., the resident consumed 3/4 of the Jell-O, 1/2 of the potatoes and green means and all but 2 bites of the meat.

On 9/5/13 at 7:55 a.m., the resident was in the dining room sitting at the table. The resident received hot cereal, banana, toast and bacon. The resident received thickened liquids of water, Boost, soda and coffee or hot chocolate. The resident ate all the toast left one of 2 pieces of bacon, and did not consume any of the hot cereal.

On 9/4/13 at 1:52 p.m., direct care staff J and K revealed that the resident's appetite depended on the day and if the resident was sleeping. If the resident was real sleepy he/she would sleep through the meals and if more awake, the resident could sometimes feed him/herself.

On 9/5/13 at 4:09 p.m., direct care staff L revealed that the resident ate very well in the evenings. One person assisted the resident with eating and drinking.

On 9/5/13 at 1:04 p.m., licensed nursing staff I

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revealed that he/she was unaware of the resident's weight situation. Staff I reported that the resident received Boost 2 times daily at meals as ordered. Arginaid 100 % taken and documented on the MAR. The resident drank the Boost and usually consumed about 75-100% of that given.

On 9/5/13 at 4:53 p.m., licensed nursing staff M revealed that the resident's appetite was good and sometimes he/she would help him/herself to eat. Licensed nursing staff M revealed he/she did not know of the resident's weight loss.

On 9/6/13 at 9:09 a.m., licensed nursing staff N revealed that the nurses gave the resident Boost at breakfast then the Arginaid at lunch. Licensed nursing staff revealed that he/she went back and looked and the resident drank about 75% of the Boost this am.

On 9/6/13 at 9:23 a.m., administrative nursing staff B talked to the dietician about this and recommended that each intervention was tried for about 1 month before changing. The administrative staff revealed he/she thought the resident was on a weight loss diet but agreed that there were no physician orders for planned weight loss.

On 9/5/13 at 5:25 p.m., administrative nursing staff A revealed the resident had a significant weight loss in from 9/12 to 3/13.

On 9/6/13 at 9:22 a.m., administrative nursing staff A revealed that the program for monitoring weight loss was not fine-tuned yet. Administrative nursing A stated the resident continued on the same intervention for about 1 month before staff

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changed the intervention.

During an interview on 9/11/13 at 12:45 p.m., consultant O revealed that residents with any weight loss would be seen every month and those without a weight loss would be seen quarterly. The consultant expected any updated information on weights from administrative nursing staff A, B and dietary O. This resident had a milk allergy and physician R reported that any resident with an allergy to milk can still receive supplements such as fortified foods and non dairy products. Times of the supplements may be changed.

Interview on 9/11/13 at 2:15 p.m., with physician R revealed that he/she was aware of the weight loss but was unable to recall specifics. The physician reported that the resident's family member died about 2 months ago. Resident's significant weight loss was in January, March of 2013 with continued weight loss. Physician R reported that the resident's weight was normally in the 160's. Physician R was unsure if the reported weight loss was significant or not.

Nursing Policy and Procedure on Nutritionally at Risk Residents with no date on the policy, revealed the purpose was: to establish guidelines for an interdisciplinary team to identify and monitor residents that are at nutritional risk.

The policy recorded:

1. A list of residents considered to be at nutritional risk will be maintained by the Director of Nursing and be taken to each Nutritionally at Risk (NAR) meeting which will be held at least monthly.

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2. The guidelines used to determine a NAR resident will be one or more of the following:
Significant weight loss (5% in 1 month; 7.5% in 3 months; 10% in 6 months)
Less than 90% of the ideal/usual body weight
Wounds
Exhibits clinical or laboratory indications
Gradual, constant weight loss

3. At each meeting the following information will be reviewed on each resident:
Care plan
Weight log
Food and fluid intake record
Intake and output record if ordered
Lab reports

4. The team will determine what recommendations will be made to address individual resident's nutritional issues. This may include request for consultation by Speech, Occupational, and Physical Therapy, Physician, Licensed Clinical Social Worker or Dentist. The team may also recommend a meeting with the resident and their family to discuss any nutritional risk issues. The local hospital's standing orders for weight loss will be put in place.

5. A newly identified NAR Resident form will be completed by the Director of Nursing, an Long Term Care charge nurse or the Certified Dietary Manager on any resident that has a significant weight loss. The assessment is given to the Director of Nursing and will be reviewed by the NAR team.

6. The NAR committee will notify the physician regarding any recommendations for treatment dietary changes, medications and/or lab work.

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Standing orders used for all weight losses:
Implement intervention 1, 2 or 3 as listed below. Implement as soon as possible except for renal patients. Nursing to provide the appropriate intervention during the medication pass time and document, on the Medication Administration Record, the portion consumed in the morning, evening and bedtime.

Interventions:
1) "5% weight loss in 1 month -16 ounce 2 Cal mixed with 1 cup ice cream this will make 24 ounce of solution divided into 3 servings of 8 ounce served cold in a cup with lid and straw notify the physician and dietician".

2) "7.5% weight loss in 3 months - 8 oz 2 Cal mixed with 1 cup ice cream this will make 16 ounces of solution divided into 3 servings of 5 ounces, 5 ounces, and 6 ounces".

3) "10 % of the weight loss in 6 months - 8 ounce of 2 Cal no ice cream served cold in 3 servings of 3 ounces, 3 ounces and 2 ounces. Notify the physician and the dietician when implementing. No protocol for residents that are allergic to milk products".

The facility failed to ensure that staff monitored and acted upon significant weight losses for resident # 5 and failed to ensure that the resident received all the supplemental nutrition prescribed to him/her by passing all the supplements ordered at all the times ordered, and to ensure the resident had no further weight loss.

- Review of resident #11's physician's orders

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sheet signed and dated on 7/24/13 revealed the resident had a diagnosis of senile dementia (short and long term memory impairment).

Review of the annual MDS (minimum data set) dated 2/13/13 revealed the resident had short and long term memory loss with moderately impaired decision making ability. The resident required extensive assist of one staff for eating. The resident's weight was 185 pounds.

Review of the ADL (activities of daily living) CAA (Care Area Assessment) dated 2/14/13 revealed the resident was alert, confused, and required staff assistance for all his/her eating.

Review of the nutritional CAA dated 2/14/13 revealed the resident was on a regular NAS (no added salt diet) and sat at the assisted dining table. The resident had a plate guard, and staff assisted to cut up his/her food. The resident consumed 75-100% the meals and his/her weight was stable. The resident was able to communicate his/her wants and needs to staff.

Review of the Quarterly assessment dated 8/20/13 revealed the resident had short and long term memory impairment with moderately impaired decision making abilities. The resident required extensive assist of one staff member for eating. The resident's weight was 185 pounds.

The care plan dated 2/4/13 and reviewed on 5/20/13 revealed the resident was at risk for nutritional deficits and received a therapeutic diet. The resident's current weight was 175 pounds and stable. The care plan directed the staff to administer the resident's medication per the

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physician's orders, encourage the resident to drink fluids, offer fluids with each episode of care, ensure the wooden board table is placed on my table when the resident in the dining room to put food and drinks on for the resident to eat independently. A care plan update on 5/29/13 revealed the resident may use a bedside table to aid in eating his/her meals. A care plan update on 5/30/13 revealed the resident may need more assistance of the staff now related to decline, honor the resident's right to refuse food and fluids, monitor the resident's legs for swelling, provide the resident with a regular NAS (no added salt) diet to decrease retention of fluids, weigh the resident at least weekly during his/her bath. and report any significant changes to the resident's physician per the protocol. A care plan update on 8/20/13 revealed the resident's current weight was 157 pounds.

Review of the resident's weight record revealed:

February 2013 - 186 pounds
March 2013 - 186 pounds
April 2013 - 174 pounds (a severe weight loss of 6.4 % in 1 month)
May 2013 - 175 pounds
June 2013 - 176 pounds
July 2013 - 166 pounds (5.6 % weight loss in 1 month)
August - 157 pounds ( a severe weight loss of 15.59 % in 6 months)

Nursing Policy and Procedure on Nutritionally at Risk Residents with no date on the policy, revealed the purpose was: to establish guidelines for an interdisciplinary team to identify and monitor residents that are at nutritional risk.

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| F 325 | Continued From page 87<br>The policy recorded:<br><br>1. A list of residents considered to be at nutritional risk will be maintained by the Director of Nursing and be taken to each Nutritionally at Risk (NAR) meeting which will be held at least monthly.<br><br>2. The guidelines used to determine a NAR resident will be one or more of the following:<br>Significant weight loss (5% in 1 month; 7.5% in 3 months; 10% in 6 months)<br>Less than 90% of the ideal/usual body weight<br>Wounds<br>Exhibits clinical or laboratory indications<br>Gradual, constant weight loss<br><br>3. At each meeting the following information will be reviewed on each resident:<br>Care plan<br>Weight log<br>Food and fluid intake record<br>Intake and output record if ordered<br>Lab reports<br><br>4. The team will determine what recommendations will be made to address individual resident's nutritional issues. This may include request for consultation by Speech, Occupational, and Physical Therapy, Physician, Licensed Clinical Social Worker or Dentist. The team may also recommend a meeting with the resident and their family to discuss any nutritional risk issues. The local hospital's standing orders for weight loss will be put in place.<br><br>5. A newly identified NAR Resident form will be completed by the Director of Nursing, an Long Term Care charge nurse or the Certified Dietary | F 325 | | |

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Manager on any resident that has a significant weight loss. The assessment is given to the Director of Nursing and will be reviewed by the NAR team.

6. The NAR committee will notify the physician regarding any recommendations for treatment dietary changes, medications and/or lab work.

Review of the standing orders developed by the facility's Registered Dietician dated 2/2013 revealed:

The supplement was provided by nursing as a med pass and must be documented on "portion consumed" at the following times of morning medication pass, afternoon medications pass and bedtime medication pass.

5% weight loss in one month
16 ounces Two Cal (dietary supplement) with 8 ounces (1 cup) of ice cream
this will make 24 oz. of solution divided into 3 servings of 8 ounces
served cold in a cup and notify the physician and dietician of significant and initiate of the standing orders.

10% weight loss in six months
8 ounces of Two Cal, no ice cream
served cold in 3 servings, two 3 ounce servings and one 2 ounce
served in a cup and notify the physician and dietician of significant and invitation of the standing orders.

Review of the Physician's Orders and Progress Record revealed an order dated 4/24/13 for the

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resident to have 16 ounces of Two Cal (a dietary supplement) mixed with 8 ounces of ice cream to make 24 ounces of solution. Divide the solution into 3 servings of 8 ounces. The order was signed by the resident's physician on 4/25/13.

Review of the September 2013 MAR (medication administration record) revealed the following orders 10 ounces of Two Cal (dietary supplement) with 8 ounces of ice cream, divide 24 ounces of solution into 3 servings of 8 ounces three times day with a start dated of 4/24/13 and an order for Arginaid (protein supplement) packet mixed in 4 ounces of water at breakfast and noon. The order for Arginaid started on 5/28/13.

Further review of the September 2013 MAR indicated the order for Arginaid was signed and circled on September 1st, 3rd, 4th and the 5th, indicating the resident did not receive it. Documentation on the back of the MAR revealed the resident refused the supplement on the 3 rd, 4th and the 5 th. The Arginaid remained unsigned on MAR for September 2nd for both scheduled supplement administration times without documentation of why the supplement was not given.

Review of Consultant O's progress notes dated 8/15/13 and titled Weight Loss note revealed: The resident was on hospice care at this time, the resident had severe weight loss of 6% in one month, 10% in 3 months, and 16.1% in 6 months. The resident received a dietary supplement of Two Cal with ice cream and Arginaid. The resident medications had been reduced will keep diet and supplementation.

On 9/5/13 observation at 7:55 a.m. revealed the

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resident received a regular diet. Staff served the resident a waffle with strawberries and butter, 2 small bowls of mandarin oranges, a bowl of cereal, 240 ml (milliliters) of juice, 240 ml of water, and 8 ounces of Two Cal served by Licensed staff P. The resident drank the 8 ounces of Two Cal prior to being offered the meal he/she was served. The resident ate 3 bites of the waffle, 2 bites of cereal, both bowls of the mandarin oranges.

On 9/5/13 at 12:25 p.m. observation revealed staff served the resident breaded chicken, mashed potatoes with gravy, cheesy broccoli, strawberry shortcake, and a small container of strawberry ice cream, 240 ml of juice, 240 ml of water, 2 ounces of Two Cal supplement. The resident drank 100% of the Two Cal supplement administered by the staff before being offered the meal. The resident ate a few bites of chicken, 85% of of the mashed potatoes, 85% of the vegetables. The resident ate two bites of the strawberry short cake and the entire container of the ice cream.

On 9/5/13 at 12:50 p.m. an interview with Licensed nurse V revealed the resident received Two Cal mixed with ice cream TID (three times a day). Staff V revealed the resident received the supplement unless the facility had a food activity that included sweets or ice cream then staff V revealed he/she would hold the resident's nutritional supplement.

On 9/5/13 at 1:44 p.m. an interview with Licensed nurse P revealed the resident refused the supplements at times. Staff P was unaware the resident had a significant weight loss. Staff P revealed the CNA's (certified nursing assistant)

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were responsible for obtaining the resident's weight with each bath. The weights were documented and given to the management team for review. The management team informed the Licensed nurses of the new intervention to put into place to enhance the resident's nutritional intake.

On 9/5/13 interview at 2:21 p.m. with Administrative nurse A revealed the facility had standing orders for weight loss developed by the Registered Dietician. The facility charge nurses were expected to initiate the standing orders when the resident had a 5% weight loss in 30 days, 7.5 % weight loss in 3 months and 10% weight loss within 6 months. Staff A revealed the physician was to be notified of significant weight loss and the initiation of the standing orders for supplementation for weight loss. Staff A confirmed the resident had no new nutritional intervention started since the identification of the significant weight loss on 8/20/13.

On 9/5/13 at 3:41 p.m. an interview with Administrative nurse B revealed the CNAs were required to weigh the resident with the resident's bath. The weights were reviewed by the dietary manager who notified Consultant O of any significant weight loss and scheduled the resident to see Consultant O on his/her next visit to the facility. Staff B revealed the dietary manager and him/herself discussed new interventions for dietary supplementations for the resident and staff B notified the resident's physician of significant weight loss and discussed possible new orders to help reduce the resident's risk for weight loss. Staff B confirmed the resident had not received any new interventions since the significant weight loss was identified on 8/20/13.

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On 9/11/13 at 12:35 p.m. an interview with Dietary consultant O revealed each resident was seen upon admission to the facility for a nutritional evaluation. Staff O revealed the residents were then seen at least quarterly for re-evaluation of their nutritional needs. Staff O revealed residents with renal problems, weight loss, and wounds were reviewed monthly and as needed. Consultant O revealed the facility was responsible for notifying him/her of the changes in the resident's weight. Staff O confirmed he/she was aware the resident had significant weight loss but the resident was on hospice and weight loss was expected. Consultant O revealed he/she expected to be notified when the standing orders for weight loss was initiated for each resident.

The facility failed to develop and monitor new dietary interventions to prevent avoidable weight loss for resident #11.

- Review of resident #30's closed medical record revealed an admission MDS (minimum date set) assessment dated 4/17/13 with a BIMS (brief interview for mental status) score of 10 (moderately impaired cognitive status). The resident required set up help with meals and received a therapeutic diet. The resident's weight was recorded as 233 pounds.

Review of the resident's ADLs (activities of daily living) CAA dated 4/17/13 (care area assessment) revealed the resident admitted from another facility related to the need for treatment of lung cancer. The resident received radiation and chemotherapy 5 days per week. The resident received a low salt, low carbohydrate

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diet. The resident ate independently and averaged a daily intake of 79% for breakfast and lunch and 91 % for supper. The resident had candy in the room that he/she snacked on. The resident took multiple snacks from the snack cart when offered. The resident had his/her own teeth and denied pain related to his/her teeth. The resident gained approximately 6 pounds since admission. The resident received chemotherapy and radiation 5 days per week and denied nausea or vomiting related to treatment at the time of the assessment.

Review of the resident's nutrition care plan dated 4/4/13 and last reviewed on 5/29/13 revealed the resident required a low carbohydrate and low fat therapeutic diet. The care plan directed the staff to provide the resident with protein, such as peanuts and milk, praise the resident when he/she had good dietary compliance, provide the resident with late night food tray, and provide the resident with as much control as possible in choosing his/her food.

Review of the care plan updated on 5/20/13 revealed the resident had began refusing most meals and fluids. The resident drank a few sips of lemonade. The care plan directed the staff to offer the resident anything he/she would like. Another care plan entry dated 5/20/13 revealed the resident had significant weight loss related to his/her refusal of foods and fluids. The care plan directed the staff to offer the resident fluids frequently and encourage small bites of food, likes peanuts and sweets.

Review of the care plan update on 5/29/13 revealed a significant weight loss in one month. The resident had chosen not to eat or drink. The

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resident would occasionally request pop or lemonade. The resident reported he/she was not hungry, did not care, and was weak and tired.

Review of the resident's weight history revealed the following:

4/4/13 - 240 pounds
4/22/13 - 240 pounds
5/1/13 - 221 pounds
5/17/13 - 222.5 pounds
5/25/13 - 220.6 pounds 8.08% weight loss in 30 days (from 4/22/13 to 5/25/13)

Review of the resident's lab dated 5/21/13 revealed a low albumin (amount of protein in the blood) level of 2.5 (normal range 3.4 - 5.4) gm/dl (grams per deciliter) and a total protein (the total amount of two classes of protein in the blood) level of 5.3 gm/dl (normal range 6.0 - 8.3 gm/dl) indicating the resident was malnourished.

Review of the progress note dated 5/10/13 revealed the resident refused medications, complained of right foot pain, he/she received chemotherapy, complained of mild lower extremity edema and mild SOA (shortness of air) with exertions. The resident received Lasix (medication to reduce fluid retention) and refused any major interventions.

Review of the resident's nurses notes dated 5/18/13 at 4:00 p.m. revealed the resident transferred to the hospital for IV (intravenous) therapy and returned at 10:30 a.m. The resident's weight upon return was 225 pounds.

Review of the nurses notes dated 5/20/13 at 10:30 a.m. revealed staff spoke with the resident

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in regard to his/her current health status. The resident reported he/she ate very little to no food, and only drank small amounts of lemonade.

Review of the dietary notes dated 4/23/13 revealed a new recommendation for 2 ounces of extra protein with meals, high protein snacks TID (three times daily) will monitor and follow the resident.

Review of the resident's record revealed no further evaluation by the Registered Dietitian after the resident had significant weight loss.

Review of the resident's record revealed no documentation or evidence the resident received the prescribed high protein snacks TID and the fourth meal tray for weight as care planned for weight maintenance.

Nursing Policy and Procedure on Nutritionally at Risk Residents with no date on the policy, revealed the purpose was: to establish guidelines for an interdisciplinary team to identify and monitor residents that are at nutritional risk.

The policy recorded:

1. A list of residents considered to be at nutritional risk will be maintained by the Director of Nursing and be taken to each Nutritionally at Risk (NAR) meeting which will be held at least monthly.

2. The guidelines used to determine a NAR resident will be one or more of the following:
Significant weight loss (5% in 1 month; 7.5% in 3 months; 10% in 6 months)
Less than 90% of the ideal/usual body weight

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| F 325 | Continued From page 96<br>Wounds<br>Exhibits clinical or laboratory indications<br>Gradual, constant weight loss<br><br>3. At each meeting the following information will be reviewed on each resident:<br>Care plan<br>Weight log<br>Food and fluid intake record<br>Intake and output record if ordered<br>Lab reports<br><br>4. The team will determine what recommendations will be made to address individual resident's nutritional issues. This may include request for consultation by Speech, Occupational, and Physical Therapy, Physician, Licensed Clinical Social Worker or Dentist. The team may also recommend a meeting with the resident and their family to discuss any nutritional risk issues. The local hospital's standing orders for weight loss will be put in place.<br><br>5. A newly identified NAR Resident form will be completed by the Director of Nursing, an Long Term Care charge nurse or the Certified Dietary Manager on any resident that has a significant weight loss. The assessment is given to the Director of Nursing and will be reviewed by the NAR team.<br><br>6. The NAR committee will notify the physician regarding any recommendations for treatment dietary changes, medications and/or lab work.<br><br>Review of the Standing Orders for Weight Loss revealed the following: | F 325 | | |

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The supplements were made by food and nutrition and provided by nursing at a med pass and were documented on portion consumed at the following time of am (med pass), pm (med pass), bed time (med pass).
5% weight loss in one month
16 ounces two Cal mixed with 8 ounces (1 cup) ice cream
this will make 16 ounces of solutions divided into 3 servings as this will make 24 ounces
served cold in a cup with a lid and straw
notify physician and dietician

Review of the resident's record revealed the standing orders for 5% weight loss protocol was not initiated for the resident on 5/25/13 when the resident was identified with a severe weight loss of 8.08% in 30 days.

On 9/5/13 interview at 2:21 p.m. with Administrative nurse A revealed the facility had standing orders for weight loss designed by the Registered Dietician. The facility charge nurses were expected to initiate the standing orders when the resident had a 5% weight loss in 30 days, 7.5 % weight loss in 3 months and 10% weight loss within 6 months. Staff A revealed the physician was to be notified of significant weight loss and the initiation of the standing orders for supplementation for weight loss. Staff A confirmed the facility failed to initiate the standing orders protocol for nutritional supplements for the resident significant weight loss of 8.08% in 30 days.

On 9/5/13 at 3:41 p.m. an interview with Administrative nurse B revealed the CNAs were required to weigh the residents with their baths.

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The weights were reviewed by the dietary manager who notified Consultant O of any significant weight losses and Consultant O to see the resident on his/her next visit to the facility. Staff B revealed the dietary manager and him/herself discussed new interventions for dietary supplementations for the resident and staff B notified the resident's physician of significant weight loss and discussed possible new orders to help reduce the resident's risk for weight loss. Staff B confirmed the facility failed to initiate the standing orders for nutritional supplements for the resident's significant weight loss.

On 9/11/13 at 12:35 p.m. an interview with Dietary consultant O revealed each resident was seen upon admission to the facility for a nutritional evaluation. Staff O revealed the residents were then seen at least quarterly for re-evaluation of their nutritional needs. Staff O revealed resident's with renal problems, weight loss, and wounds were reviewed monthly and as needed. Consultant O revealed the facility was responsible for notifying him/her of the changes in the resident's weight. Consultant O revealed he/she expected staff to notify him/her when the standing orders for weight loss was initiated for each resident. Staff O confirmed he/she was unaware of the resident's significant weight loss in 30 days.

On 9/11/13 at 2:12 p.m. an interview with Physician R revealed the resident had stage 3 lung cancer and was transferred to the facility to have access to chemotherapy and radiation treatments. The resident refused medications, meals, and personal care. Physician R revealed

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| F 325 | Continued From page 99<br>he/she was aware that the resident had lost weight during his/her stay at the facility. Staff R revealed he/she was not certain he/she was aware the weight loss was severe. Staff R revealed his/her progress notes did not address the resident's significant weight loss, just the continued refusal to eat. Physician R revealed his/her expectations of the facility was to notify him/her of the resident's significant weight loss and initiate treatment per the standing orders and prescribed treatment plans developed by the facility.<br><br>The facility failed to identify the avoidable severe weight loss of 8.08% in 30 days and failed to implement nutritional interventions to help reduce the risk for further weight loss for resident #30. | F 325 | | |
| F 334 SS=E | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following: | F 334 | | |

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| F 334 | Continued From page 100<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal | F 334 | | |

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immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 33 residents. The sample included 5 residents, all with a signed consent for pneumococcal vaccines for the fall of 2012. Based on record review and interview, the facility failed to follow their policy for administration of the pneumococcal vaccine for 5 of 5 sampled residents (#32, #21, #23, #18 and #14) with a signed consent for such and failed to have information as to the date 3 of the 5 sampled residents (# 23, #18,and #14) last received a pneumonia vaccine.

Findings included:

- Review of resident immunization records for residents #32, #21, #23, #18 and #14 revealed that all 5 residents agreed to accept the pneumococcal vaccine in the fall of 2012. Review of each resident's immunization records lacked administration of the vaccine for the fall of 2012. Review of the records revealed the lacked information as to why each of the residents did not receive the vaccination or that the staff had contacted the physician for approval to give, or not give the vaccination.

Interview with administrative nursing staff A on 9/5/13 at 12:11 p.m. revealed he/she did not know why the residents did not receive the pneumonia vaccination or why the physician had

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not been contacted for approval.

Review of the records for all 5 residents revealed 3 of the resident's (#23, #18 and #14) records did not have a date for administration of the last pneumonia vaccination.

Review of the facility policy for Pneumococcal Vaccination, last revised 1/21/10, revealed "Each resident's pneumococcal immunization status will be determined upon admission or soon afterwards and will be documented in the resident's medical record. Current residents will have their immunization status determined by reviewing available past and present medical records... All residents with undocumented or unknown pneumococcal vaccination status will be offered the vaccine... All residents should receive the pneumococcal vaccine if they are 65 years of age or older. Those residents that are younger than 65 should have the pneumococcal vaccine if they have increased susceptibility to infection or increased risk for serious disease and its complications... Residents 65 years or older should be administered a second dose of vaccine if they received the first dose of vaccine more than 5 years earlier and were less than 65 years old at the time... Informed consent in the form of a discussion regarding risks and benefits of vaccination will occur prior to vaccination. This may by the resident's authorized representative when appropriate... Document administration of the vaccine in the resident's medical record..."

The facility failed to implement their policy for Pneumococcal Vaccination by the failure to include documentation in the medical record of the immunization status for the pneumonia vaccine and failure to notify the physician the

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| F 334 | Continued From page 103<br>resident/family had consented to receive a second pneumonia vaccine and to determine if the residents were eligible for a second dose. | F 334 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility census totaled 33 residents. The dietary staff prepared meals for all residents in the main kitchen. Based on observation, interview and record review the facility failed to store and distribute food under sanitary conditions by storing individual serving bowls upside down on a rusty shelf, handling glasses and straws by the drinking surfaces, and storing salad dressing in a container labeled as the original condiment (Ice Cream topping) in the container. This had the potential to affect all 33 residents.<br><br>Findings included:<br><br>- Observation during the initial kitchen tour on 9/3/13 revealed kitchen staff stored bowls upside down on a rusty shelf and handled drinking glasses by the drinking surface when serving drinks. | F 371 | | |

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Observation on 9/5/13 at 11:38 a.m. revealed dietary staff W wore gloves to serve strawberry shortcake and strawberry ice cream cups. Staff W touched the handles of tongs, the outer bag of the whipped topping, the steam table shelf, the outside of the soda cans, and did not change gloves prior to grabbing drinking glasses by the drinking rims for four residents. Staff W then poured soda into the glasses and put the glasses on the resident's meal tray for all four of the residents.

Observation on 9/4/13 at 11:52 a.m. revealed direct care staff E handled two drinking glasses by the drinking surface as he/she filled the cups with milk and juice for a resident. Staff E then opened drinking straws for the resident's two drinks and handled the straws by the drinking surface.

Interview with dietary staff Q on 9/5/13 at 12:30 p.m. revealed he/she had the expectation that kitchen staff would not touch the drinking surface of glasses when handling the glasses.

Observation during the initial kitchen tour on 9-3-13 at 7:45 a.m. revealed debris on the inside of the ice machine lid. Ice scoops lay on a stainless steel table with crumbs in the same area as the scoops. Interview with dietary staff Q at that time revealed the expectation for staff to store the scoops in a different place free of crumbs or debris.

Observation on 9-3-13 at 7:45 a.m. during initial tour of the kitchen revealed undated ice cream topping bottles in the refrigerator. Further observation revealed the undated containers

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| F 371 | Continued From page 105<br>contained salad dressing rather than ice cream topping, as indicated on the original label on the bottle.<br><br>The facility failed to ensure the sanitary distribution and storage of food used for all 33 residents. | F 371 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit | F 431 | | |

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package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 33 residents. Based on observation and interview, the facility failed to ensure staff properly labeled and stored insulin (a medication to control blood sugars) flexpens(insulin dispensing devices) and properly labeled an insulin vial. This had the potential to affect 5 residents that received insulin.

Findings included:

- Observation on 9/3/13 at 10:23 a.m. revealed a Novolog insulin flexpen without a legible open date. It appeared as if someone had attempted to mark the open date with a black marker and the ink had smudged.

Observation on 9/3/13 at 10:23 a.m. revealed an opened vial of Lantus insulin with no open date on the vial in the refrigerator.

Interview on 9/3/13 at 10:25 a.m. with licensed nursing staff I confirmed he/she could not read the open date on the Novolog flexpen and the Lantus vial did not have an open date on it.

Interview on 9/6/13 at 10:38 a.m. with administrative nursing staff A revealed the medication room were checked monthly by direct care staff W for expired or undated medication. Staff A confirmed he/she expected the insulin pens to have the resident's name and date

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opened.

Review of the facility policy for Insulin Flex Pens, with no date of revision, revealed "
Un-refrigerated Pens should be discarded 42 days after it is first kept out of the refrigerator.
After initial use... Write the Resident's name on the Pen and the date opened..."

The facility failed to properly label opened insulin containers which had the potential to affect 5 residents that received insulin.

- Observation on 9/5/13 at 6:25 a.m. revealed 4 insulin pens sitting on top of the unattended medication cart in the north hall. At 6:33 a.m. licensed nursing staff P came out of a resident room and went to the cart. When asked what the 4 items were on top of the cart staff P confirmed they were insulin pens. When asked where staff store them staff P said in the medication room. At 6:35 a.m., Staff P then left the pens there while he/she went into another resident room. Staff P came out of the resident room at 6:40 a.m., went to the cart, prepared medications for another resident, then took the medications to the resident. During this time a resident came down the hall ambulating independently with a walker and stopped to visit with the surveyor. The resident started laughing for no apparent reason, said something the surveyor could not understand, then said he/she (the resident) had better go because "he/she" was really grouchy.

Observation of the medication cart on 9/5/13 at 7:00 a.m. revealed the insulin pens remained unsecured on top of it. At 7:15 a.m. and at 7:30 a.m., the insulin was in the same location as before. At 8:00 a.m., only 3 pens were visualized.

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| F 431 | Continued From page 108<br>At 8:20 a.m., 3 insulin pens still remained on top of the cart. Two are Humulin insulin, one with the initials NG and another with the initials BH, and the third insulin pen was Novolog for MA.<br><br>Interview on 9/6/13 at 10:38 a.m. with administrative nursing staff A revealed he/she expected that if an insulin pen did not have a needle on it, it did not need to be secured, but if it had a needle on it and had been dialed with the dosage of insulin to be given, it should be stored in an area inaccessible to residents.<br><br>The facility failed to store insulin pens in a secure manner. This failure had the potential to affect the 5 residents that received insulin. | F 431 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to | F 441 | | |

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prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 33 residents. Based on observation, record review, and interview, the facility failed to implement appropriate infection control isolation precautions for one resident (#33) with MRSA (methicillin-resistant staphylococcus aureus) in his/her sputum, which had the potential to effect the resident's roommate.

Findings included:

- Observation on 9/3/13 at 11:32 a.m. revealed a contact precautions sign on the door for resident #33. All of the isolation personal protective equipment hung in an organizer on the door to the residents' room. The room housed two residents.

Observation on 9/3/13 during initial tour revealed

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several unassigned resident rooms.

Observation on 9/3/13 at 3:00 p.m. revealed the room divider curtain was open and neither resident had isolation personal protective equipment in place.

Review of resident #33's chart revealed the resident had been admitted on 6/5/13 with MRSA in his/her sputum.

Review of the sign on the resident's door revealed the box next to "private room" had been checked "yes".

Interview with administrative nursing staff A on 9/3/13 at 3:30 p.m. revealed resident #33 was recently re-admitted from the hospital with a diagnosis of MRSA in his/her sputum and staff placed the resident in a room with a roommate because there were no unassigned rooms at the time. Staff A reported resident #33 could have a roommate as long as the room divider curtain remained pulled closed.

Interview on 9/4/13 at 11:25 a.m. with a family member revealed resident #33 had been admitted with an infection in the lungs a month or so ago and received antibiotics when he/she was admitted to the facility. The family member reported he/she had met with the resident's physician the week before the interview and the physician had told him/her that as long as the resident coughed, he/she should wear a mask.

According to the Center for Disease Control guidelines for precautions to prevent the spread of MRSA in healthcare settings, "In Patient placement in hospitals and LTCFs [long term

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| F 441 | Continued From page 111<br>care facilities], when single-patient rooms are available, assign priority for these rooms to patients with known or suspected MRSA colonization or infection. Give highest priority to those patients who have conditions that may facilitate transmission e.g. [example] uncontained secretions or excretions. When single-patient rooms are not available, cohort patients with the same MRSA in the same room or patient-care area. When cohorting patients with the same MRSA is not possible, place MRSA patients in rooms with patients who are at low risk for acquisition of MRSA and associated adverse outcomes from infection and are likely to have short lengths of stay."<br><br>Review of the facility policy for Contact Isolation, last revised 5/11, revealed "Purpose: To provide an effective method of preventing the spread of drug resistant organisms during Contact Isolation in the long term care setting without diminishing from the home-like environment or ostracizing the LTC resident in their home... Contact Isolation is recommended for the following dx [diagnosis]: ... MRSA... Any LTC resident with any of the above active diagnosis will be placed in Contact Isolation per Standing Order... Notes in regard to MRSA of sputum (if cohorting): 1) The curtain between the MRSA resident and room-mate should be pulled at all times..."<br>The facility failed to implement contact precautions for a resident with MRSA in his/her sputum per CDC recommendations and the facility policy. This had the potential to affect the roommate of resident #33. | F 441 | | |
| F 520 SS=F | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS | F 520 | | |

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A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 33 residents/ Based on interview and deficiencies identified during the annual survey completed on 9/6/13, the facility failed to develop and implement an effective system to ensure that action plans were developed through the Quality Assessment and Assurance (QAA) program, to address concerns in regards to notification of change, revision of care plans, provision of care, prevention of pressure ulcers, nutrition/weight loss, free of accidental hazards, failure to provide

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pneumococcal immunizations to residents, improper storage of insulin pens, improper labeling of insulin pens and vial, preparing and serving food in a sanitary manner. ineffective infection control program.

Findings included:

- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to develop an effective monitoring and review system for notification of change. Please see F-157 for additional information.

- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to develop an effective monitoring and review system for revision of care plans. Please see F-280 for additional information.

- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to develop an effective monitoring and review system for provision of care. Please see F-309 for additional information.

- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to develop an effective monitoring and review system for prevention of pressure ulcers. Please see F-314 for additional information.

- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to develop an effective monitoring and review system for the prevention of accidental hazards. Please see F-323 for additional information.

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| F 520 | Continued From page 114<br><br>- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to develop an effective monitoring and review system for nutrition/ weight loss. Please see F-325 for additional information.<br><br>- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to develop an effective monitoring and review system for the provision of Influenza/Pneumococcal immunizations. Please see F-334 for additional information.<br><br>- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to develop an effective monitoring and review system for storing/preparing and serving food in a sanitary manner. Please see F-371 for additional information.<br><br>- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to develop an effective monitoring and review system for drug/biological labeling and storage. Please see F-431 for additional information.<br><br>- Based on interviews on 9/6/13 at 12:00 p.m., with administrative staff X revealed that the facility failed to implement appropriate infection control isolation procedures. Please see F-441 for additional information. | F 520 | | |